Ministry of Health, Kenya

Trainer’s manual on clinical care for survivors of sexual violence
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AIDS acquired immune deficiency syndrome
ARV antiretroviral
CCC comprehensive care centre
DNA deoxyribonucleic acid
EC emergency contraception or contraceptive
HIV human immunodeficiency virus
HVS high vaginal swab
LFT liver function tests
OPD outpatient department
PEP post-exposure prophylaxis
PID pelvic inflammatory disease
PRC post-rape care
STI sexually transmitted infection
VCT voluntary counselling and testing

Operational definitions

Children people younger than 12 years
Penetration the partial or complete insertion of the genital organ of one person into the genital organ of another person
Foreword

Survivors of sexual violence usually come to the health institutions for medical care. The care differs from institution to institution, hence the need for a manual to help health care providers deliver standardized, comprehensive post-rape care.

This training manual on forensic and clinical care for sexual violence survivors is intended to contribute to the efforts by various stakeholders to address sexual violence. The manual will aid health care providers in managing sexual violence survivors clinically. It will provide those in health facilities with the knowledge, skills and information to ensure all survivors of sexual violence are handled in the best and most professional manner. This manual guides health care providers to undertake forensic examination, specimen collection, analysis and documentation and to provide clinical management to survivors. The manual has a section on counselling, to emphasize the necessity for counselling and its implications in clinical management and to equip health care providers to provide basic counselling.

We hope this manual will contribute to the skills of health care providers in the managing sexual violence survivors.

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Ministry of Health
Acknowledgements

This manual has been adapted from two manuals:


Information has been incorporated from the *National Guidelines on Medical Management of Rape and Sexual Violence* (Kenya, Ministry of Health 2004) and the *A New Approach to Supervision: Facilitative Supervision Manual for Supervisors of Reproductive Health Services* (Kenya, Ministry of Health 2005).

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Preface

Since 2005 the Ministry of Health’s Reproductive Health Division has worked with others to develop a system to deliver rape survivor care in public health facilities. It reviewed manuals different organizations used to train health care providers in comprehensive rape survivor care. Stakeholders met and outlined the manual’s purpose and structure. A draft was completed in December 2005 and distributed for review; many suggestions have been incorporated.

This manual was developed to aid in training health care providers, doctors, clinical officers, laboratory technicians and nurses to deliver post-rape care, register care sites, support supervision and monitor the systems. It should be used in its entirety. Module 1 focuses on legal aspects of care while module 2 focuses on managing post-rape care.
Clinical care for survivors of sexual violence

Goal
Facilitate delivery of standardized and comprehensive post-rape care services in health care facilities in Kenya.

Objectives
By the end of the course the participants will be able to

- Discuss the legal concepts, requirements and implications for health providers in providing care to sexual violence survivors.
- Develop skills in forensic examination, collecting specimens, analysing and documenting procedures and protocols in managing sexual violence survivors.
- Describe the importance of clinical evaluation and managing comprehensive sexual violence care, including post-exposure prophylaxis, emergency contraceptives and sexually transmitted infections.
- Analyse the need for comprehensive counselling, including the intersections between counselling and clinical care for sexual violence survivors.
- Review referral systems for providing comprehensive post-rape care in health facilities.
- Establish management, supervision, and measuring and evaluation systems.

Course structure
The training manual is divided into 2 modules with 8 eight units. All units are geared toward enhancing the participants’ capacity to provide post-rape services within public and private health facilities.

Module 1: Medical and legal aspects of post-rape care
Unit 1: Sexual violence and the law
Unit 2: Comprehensive clinical care
Unit 3: Forensic examination and collecting specimens
Unit 4: Counselling

Module 2: Managing post-rape services
Unit 5: Referral mechanisms
Unit 6: Registration and information management
Unit 7: Supervision for quality improvement
Unit 8: Monitoring and evaluation
Target group
This manual should be useful for doctors, clinical officers, nurses and laboratory personnel who give post-rape care at health facilities in:

- Casualty or any service delivery point where clients present first after sexual violence
- Comprehensive care clinics and patient support centres where ongoing management of PEP, mother-and-child health (MCH), EC and STI is undertaken and laboratories where survivors are referred for tests and examinations

**There must be gender balance in selecting trainees from each health facility.**

Duration
This is a residential 3-day short course. Participants will report the evening before the course starts and leave the morning of the fourth day. (annex 1)

Note: The facilitator should have the participants evaluate each day’s lessons after 4 p.m.

Facilitators
The facilitators should be qualified in the topics covered and involved in providing post-rape services.

Method
The training will include illustrated lectures, case study presentations, practical demonstrations and plenary discussions.
Day 1

Introduction and setting climate

<table>
<thead>
<tr>
<th>Duration</th>
<th>30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>By the end of the session the entire group will be able to</td>
</tr>
<tr>
<td></td>
<td>• officially welcome and introduce each other</td>
</tr>
<tr>
<td></td>
<td>• identify participant expectations for the training</td>
</tr>
<tr>
<td></td>
<td>• create ground rules or norms and choose group leaders</td>
</tr>
<tr>
<td></td>
<td>• state the training objective</td>
</tr>
<tr>
<td></td>
<td>• administer a pre-test (annex 2)</td>
</tr>
</tbody>
</table>

Introducing participants

Participants may be paired and asked to introduce each other. The introduction may include the partner surnames, likes and dislikes and experience in managing rape survivors.

Group norms

The whole group will develop a group contract to indicate the training rules. The ground rules should be written on a flip chart and displayed.

Participant expectations

The facilitator should distribute coloured visualization in participation programmes (VIPP) cards and ask the participants to write their expectations and fears on issues that may deter them from gaining fully from the training. This should be followed by a supportive session that discusses their expectations and deals with the fears.

Course objectives

Well before the course the objectives should be written on a flip chart or on a slide and shared with the participants. It should be compared with the participants’ expectations. If some expectations do not tally with the objectives, they should be written on a flip chart labelled ‘Parking bay’ and tackled, if possible, at the end of the workshop.
UNIT 1: Sexual violence and the law

Duration 120 minutes

Objectives By the end of the session participants will be able to

- Review concepts of gender and gender-based violence.
- Describe and classify sexual violence.
- Clarify sexual violence myths, stereotypes and realities.
- State sexual violence effects.
- Identify the gaps in the Kenyan law and the implications on services.
- Explain chain of evidence custody.
- Discuss the legal procedures in managing sexual violence survivors.
- State the role of health care providers as expert and professional witnesses.

A lawyer should conduct this session.

1.1 Review concepts of gender and gender-based violence

Method The group discusses what gender violence means.

Key point This course will centre on sexual violence issues. Emphasis is placed on caring for and managing survivors of sexual violence who come to the health facilities.

Content

‘Sex’ is a biological classification of females and males, defining physical differences between them.
'Gender' is a social construct that defines differentiated roles of men and women, boys and girls. Gender is also a social idea of femininity and masculinity, which is learned rather than innate. It varies by culture, time and place. The construction of gender takes place in all social institutions, such as family, educational institutions, religious institutions and workplace. Various factors determine how gender is socially constructed in such institutions. The construction of gender could arise out of observation or remarks made or actions taken.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dynamic</td>
<td>Static</td>
</tr>
<tr>
<td>Geographical</td>
<td>Universal</td>
</tr>
<tr>
<td>Learned</td>
<td>Innate</td>
</tr>
<tr>
<td>Social</td>
<td>Biological</td>
</tr>
<tr>
<td>Construct</td>
<td>Classification</td>
</tr>
</tbody>
</table>

'Gender roles' are defined as social expectations of what men and women should do in different environments, based on the cultural ideas of masculinity and femininity. Gender roles are culturally determined and are learned. They differ from one society to another.

'Sex roles' are from nature; they are genetically determined characteristics of male and female, such as pregnancy and childbirth.

<table>
<thead>
<tr>
<th>Gender roles</th>
<th>Sex roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rearing</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Feeding</td>
<td>Breastfeeding</td>
</tr>
<tr>
<td>Mechanical engineering</td>
<td>Childbirth</td>
</tr>
<tr>
<td>Piloting</td>
<td>Impregnating</td>
</tr>
<tr>
<td>Household chores</td>
<td></td>
</tr>
</tbody>
</table>

'Gender equity' promotes equal opportunity and fair treatment for men and women personally, socially, culturally, politically and economically. It is based on fairness and justice.

'Gender equality' is where men and women are seen to be equal, such as women and men having equal access to education.
‘Gender sensitivity’ is theoretical, when a person or program recognizes that gender roles are socially constructed and can be changed.

‘Gender responsiveness’ is a when a person or a program practises gender sensitivity. Actions address gender unfairness and discrimination, promote equity for women and men and include their empowerment and advancement.

**Gender-based violence**

‘Gender violence’ (GBV) is the term used to distinguish violence that targets individuals or groups by their gender from other forms of violence (UNHCR—the United Nations High Commissioner for Refugees).

Gender-based violence includes rape, torture, mutilation, sexual slavery, forced impregnation and murder. It can be defined and categorized as physical, sexual, psychological, emotional or economical violence. Sexual violence can be categorized by the characteristics of the survivor, by focusing on child sexual abuse or sexual assault against an adolescent or adult woman, or by the kinds of perpetrators. For example, ‘intimate partner violence’ groups all violence against women perpetrated by their boyfriends or husbands. In addition, legal categories of violence differ from country to country.

Any act is gender violence if it results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of coercion or arbitrary deprivation of liberty in public or private life (UN 1993).

**Domestic violence** is physical, psychological or economical abuse of a woman by her partner or ex-partner(s) or by a person within the home or family:

- Physical violence includes punches, mutilation, burns, use of arms and domestic incarceration.
- Emotional or psychological violence encompasses humiliation, exploitation, intimidation, psychological degradation, verbal aggression and deprivation of freedom and rights.
- Economic violence covers economic blackmail, taking away the money the woman earns so the male partner has an absolute control over the family income.

Perpetrators can include the partner, ex-partner, father, any family member, and another person at home. Gender-based violence violates human rights principles enshrined in international human right instruments:

- Right to life, liberty and personal security.
- Right to the highest attainable mental and physical growth.
• Right to freedom from torture or cruel, inhuman or degrading treatment or punishment.
• Right to freedom of movement, opinion, expression and association.
• Right to enter into marriage with free and full consent and entitlement to equal rights to marriage, during marriage and its dissolution.
• Right to education, social security and personal development.
• Rights to cultural, political and public participation with equal access to public services, work and equal pay for all work.

1.2 Describe and classify sexual violence

<table>
<thead>
<tr>
<th>Duration</th>
<th>30 minutes</th>
</tr>
</thead>
</table>
| **Method 1** | In the plenary session, ask participants to volunteer definitions and the facilitator will give the legal definitions:  
• Read case studies 1–4 (annex 3).  
• Ask participants to divide into four groups and give each group a case study.  
• Allowing 15 minutes for discussion, request each group to decide if the study they read could be considered rape and why.  
• After allowing each group to report their ideas to the whole group, state the definition of rape.  
• Explain that the definition shows the women and girls in all the four stories were raped. |

or

| Method 2 | A lawyer gives a lecture on sexual violence from a legal view.  
The lawyer needs to  
• Define the types of sexual violence in Kenya.  
• Explain each definition in depth. |

Content

The World Health Organization (WHO) defined sexual violence as ‘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’ (WHO 2002b). Sexual violence includes sexual contact by one person to another against their will and may include forced penetration of the vagina or anus with a penis or other object, touching the perineum including the penis, vagina or anus, oral sex (placing the mouth or tongue on a person’s vagina, penis or anus), rubbing a penis, hand or other object against another person’s perineum and performing such acts with an animal. However, the law defines each of these activities differently.

*Carnal knowledge* is penile-vaginal penetration within legal discussions. While the anus and mouth can also be penetrated by a penis, the assumption has been that when these orifices are mentioned, the term *against the order of nature* is added in the law. The law presumes sexual behaviour should be between adults of the opposite sex. Natural acts include only a penis and vagina. Therefore, when sexual activity, including penetration, is outside this assumption, it is regarded as unnatural and described as ‘*against the order of nature*’. Consent is not considered.

**Content**

The following have been adopted from the Sexual Offences Act, 2006:

**Section 3(1) rape**
A person commits the offence termed rape if
a) He or she intentionally and unlawfully commits an act which causes penetration with his or her genital organs,
b) The other person does not consent to the penetration, or
c) The consent is obtained by force or by threats or intimidation of any kind.

**Section 4 attempted rape**
Any person who attempts to unlawfully and intentionally commits an act that causes penetration with his or her genital organs is guilty of attempted rape.

**Section 5(1) sexual assault**
Any person who unlawfully
d) Penetrates the genital organs of another person with
   i) Any part of the body of another or that person; or
   ii) An object manipulated by another or that person except where such penetration is carried out for proper and professional hygienic or medical purposes;
(e) Manipulates any part of his or her body or the body of another person to cause penetration of the genital organ by any part of the other person’s body, is guilty of sexual assault.

**Section 6 compelled or induced indecent acts**

Any person, who intentionally and unlawfully compels, induces or causes another person to engage in an indecent act with

f) The person compelling, inducing or causing the other person to engage in the act;

g) A third person;

h) That other person himself or herself; or

i) An object, including any part of the body of an animal, in circumstances where that other person

   i) Would otherwise not have committed or allowed the indecent act; or

   ii) Is incapable in the law of appreciating the nature of an indecent act;

   iii) Is guilty of an offence.

**Section 8 defilement**

**Section 8(1)**

A person who causes penetration with a child is guilty of an offence called defilement.

**Section 8(2)**

A person who defiles a child aged 11 years or less shall upon conviction be sentenced to imprisonment for life.

**Section 8(3)**

A person who defiles a child between the age of 12 and 15 years is liable, upon conviction, to imprisonment for not less than 20 years.

**Section 8(4)**

A person who defiles a child between the age of 16 and 18 years is liable upon conviction to imprisonment for not less than 20 years.

**Section 9(1) attempted defilement**

A person who attempts to cause penetration with a child is guilty of attempted defilement.

**Section 12 promoting sexual offences with a child**

A person who

j) Manufactures or distributes any article that promotes or is intended to promote a sexual offence with a child, or

k) Who supplies or displays to a child any article intended for performing a sexual act with the intention of encouraging or enabling that child to perform such sexual act, is guilty of an offence.
Section 20(1) incest by male persons

Any male who commits an indecent act or causes penetration with a female person who is, to his knowledge, his daughter, granddaughter, sister, mother, niece, aunt or grandmother is guilty of incest. If it is alleged and proved that the female person is under the age of 18 years, it shall be immaterial that the act was with the consent of the female person.

Section 21 incest by female persons

Section 20 shall apply *mutatis mutandis* with respect to any female who commits an indecent act or causes penetration with a male person who is, to her knowledge, her son, father, grandson, grandfather, brother, nephew or uncle.

Section 22(1) test of relationship

In incest, brother and sister includes half brother, half sister and adoptive brother and adoptive sister and a father includes a half father and an uncle of the first degree and a mother includes a half mother and an aunt of the first degree whether through lawful wedlock or not.

Section 22(2) in this Act

l) ‘uncle’ means the brother of a person’s parent and ‘aunt’ is the sister,
m) ‘nephew’ means the male child of a person’s brother or sister and ‘niece’ is the female child,
n) ‘half brother’ means a brother who shares only one parent with another
o) ‘half sister’ a sister who shares only one parent with another, and
p) ‘adoptive brother’ means brother who is related to another through adoption and ‘adoptive sister’ a sister related through adoption.

Section 23(1) sexual harassment

Any person in a position of authority or holding a public office who persistently makes any sexual advances or requests, which he or she knows, or has reasonable grounds to know, are unwelcome, is guilty of sexual harassment.

Other sexual offences include

- Gang rape
- Indecent act with child or adult
- Child trafficking
- Child sex tourism
- Child prostitution
- Child pornography
- Exploitation of prostitution
- Trafficking for sexual exploitation
- Prostitution of persons with mental disabilities
• Sexual offences relating to position of authority and persons in position of trust
• Sexual relationships that pre-date position of authority or trust
• Deliberately transmitting HIV or any life-threatening sexually transmitted disease
• Administering a substance with intent
• Cultural and religious offences
• Not disclosing conviction of sexual offences

1.3 Sexual violence myths, stereotypes and realities

<table>
<thead>
<tr>
<th>Method</th>
<th>Explain to the participants that statements will be read out and they should decide whether a statement is true or false. After each statement, those who think the statement is true should move to the right of the room and those who think it is false should move to the left. Make a provision for those who are not sure.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Women are raped by strangers in dark places outside the home.</td>
</tr>
<tr>
<td></td>
<td>• Rape of men is more shameful than that of women.</td>
</tr>
<tr>
<td></td>
<td>• There is no rape in marriage.</td>
</tr>
<tr>
<td></td>
<td>• Women say ‘No’ when they mean ‘Yes’.</td>
</tr>
<tr>
<td></td>
<td>• Men rape because they are overcome by sexual urges.</td>
</tr>
<tr>
<td></td>
<td>• Men who rape are obviously not normal.</td>
</tr>
</tbody>
</table>

| Key point                           | Women have been socially and historically conditioned to be dependent, please others, be passive, be indecisive and be self-doubting. This social conditioning leaves women vulnerable to sexual violence and may affect whether or not they seek support after a sexual assault. Fearing the displeasure and shame they may provoke in their families, many women decide to remain silent. |

After this exercise, remind the participants that rape is about power and domination and that every man has self-control. The facilitator should also revisit controversial issues, such as dressing.

Note: Different people will have differing views on the statements. The facilitator needs to stress there are no right or wrong answers because our values determine our responses.
Content

Myth: Women ask to be raped.
Fact: Rape is violent and humiliating. The rapist often uses threats and life endangering force, so the survivor fears injury or death. No one asks for the fear and trauma of rape.

Myth: ‘Young attractive girls’ get raped.
Fact: Rapists do not choose survivors by appearance or age. Any woman may be raped. The age range of survivors is from 2 days to 103 years.

Myth: Rapists are strangers.
Fact: Studies show that 60–75% of rapists know their survivors. Acquaintance rape and date rape are a real danger, especially for teens and young adults.

Myth: Sexual violence is impulsive, done for sexual gratification.
Fact: Most rapes are planned in advance. The rapist stalks a victim or waits for a safe opportunity and finds a victim. Sexual gratification is not the motive for rape; it is an act of anger, aggression and control with sex used as a weapon.

These myths
- Increase the trauma experienced by the survivor.
- Encourage prejudice about the legal liability of both the survivor and the accused.
- Slow down or prevent the recovery of the survivor.
- Discourage survivors from reporting the rape as a crime.
- Help lawyers assist offenders escape conviction or reduce their sentence.
- Hamper society’s understanding of sexual violence and the serious effect it has on survivors.

Survivors are denied the support and assistance they need to heal from sexual violation.

1.4  : Realities of sexual violence

<table>
<thead>
<tr>
<th>Method 1</th>
<th>Group participants in pairs. Let them come up with reasons given for rape and share them with the class.</th>
</tr>
</thead>
<tbody>
<tr>
<td>or</td>
<td></td>
</tr>
<tr>
<td>Method 2</td>
<td>All participants discuss the reasons given for rape and sexual violence. Allow participants to give their views and discuss why none of the reasons is valid. The facilitator could lead a discussion</td>
</tr>
</tbody>
</table>

12  / Clinical Care for Survivors of Sexual Violence
on how a community perpetuates rape and sexual violence by maintaining silence whenever it occurs within families or other social networks, or preferring to settle such disputes within the family or community.

**Note to remember**  
Sexual violence is a crime. No sexual crime can be justified. Sexual violence takes away a person’s worth. This has to be clear and with participant consensus for the session to continue.

**Learning point**  
Each society has different values and people have differing opinions about why rape happens. REGARDLESS, SEXUAL VIOLENCE AND RAPE ARE CRIMES AGAINST A PERSON AND THE STATE. THEY CANNOT BE JUSTIFIED.

### 1.5 : Establishing the effects of sexual violence

**Method**  
Identify the possible effects of rape and sexual violence, keeping in mind the discussions just taken place. Categorize the effects into psychological, behavioural and physical. Use short suggestions that do not require much discussion. Write the ideas on a flip chart and hang it in the room. They shall be revisited and categorized throughout the training.

**Materials**  
Handout, ‘Sexual violence effects’ (annex 4)

**Learning point**  
The effects and manifestations of rape and sexual violence differ from one survivor to another. The health care provider needs to be able to identify the effects their clients experienced to know how to support and refer them appropriately.

### 1.6 : Gaps in the law and their implications on services

**Method**  
Refer to the previous section on legal definitions (1.2, p. 20-24/113). Ask participants to highlight gaps in current Kenyan law that may have affect service delivery. Refer also to the local understanding of sexual violence and how it affects services.
Issues that need to be reflected in these discussions:

- The lack of clear definition for forced anal penetration.
- Marital rape not recognized in Kenyan law and social structures.

Learning point

Participants must understand that, despite these gaps, as health care providers, they should ensure all survivors who report to their facilities get medical attention without being judged in any way.

1.7 Legal procedures in managing survivors of sexual violence

Method

Present an illustrated lecture:

- Do’s and don’ts after a sexual assault
- Reporting procedures at the police station
- Legal documentation, filling in PRC 1 and PRC 2 forms (annexes 5 and 6).

Content

**What NOT to do after a sexual assault**

Wanting to wash, shower, and change clothes is a natural impulse after a sexual assault, but the survivor should wait.

**Do not**

- Brush hair.
- Shower, bathe or ‘clean up’ because this will destroy important evidence.
- Disturb the location where the event took place because the crime scene contains important evidence.
- Change clothing.
- Destroy or wash clothing.
- Put clothes in a plastic bag.

**What to do after a sexual assault**

- Wrap the clothes in a newspaper or brown paper bag.
- Go to the nearest police station or hospital.
Reporting to the police

- A record will be made in the occurrence book (OB) and the survivor will be given an OB number.
- The police will ask questions about the incident; this should be done in privacy.
- The survivor, if an adult, will be asked to record a statement and sign it.
- The survivor will be provided a P3 form, to be filled in and signed by the doctor after the survivor fully recovers from all injuries.

Filling out the PRC 1 and PRC 2 forms

- These forms should be completed in triplicate.
  - The white copy should be given to the survivor.
  - The yellow copy is attached to the P3 form and given to the police, in case the survivor had not reported the incident to the police.
  - The green copy is retained as a hospital copy.
- The Post-Rape Care 2 (PRC 2) form should be filled out by the clinician doing the survivor monitoring visits.

1.8: Health care providers as expert court witnesses

| Method | The participants mention what they believe their role is in the medical and legal issues around sexual violence. |

Content

The health care provider when in court should

- Be able to give facts the survivor presented.
  - Health care providers need to relate the actual events presented by the client and not interpret them.
- Look professional and dress appropriately.
- Speak clearly, slowly and loud enough.
- Use plain language and not jargon.
- Not give information beyond what is asked.
- Treat legal practitioner(s) with respect.
- Not be afraid to say, ‘I don’t know’.
- Not lose objectivity by wanting to please.
• Refer to books, notes and written information, when presenting evidence.
• Not equivocate, but not draw conclusions unless certain.
• If giving evidence on behalf of another doctor, keep to the report made by that doctor.
• When giving opinions on the assault, consider
  o condom use
  o whether there was too much bleeding
  o if there was penetration and no ejaculation
  o biological failure of the man to ejaculate

UNIT 2: Comprehensive clinical care

<table>
<thead>
<tr>
<th>Duration</th>
<th>120 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>By the end of the session participants will be able to</td>
</tr>
<tr>
<td></td>
<td>• Describe managing physical injuries peculiar to sexual violence.</td>
</tr>
<tr>
<td></td>
<td>• Discuss HIV transmission and post-exposure prophylaxis and sexual violence.</td>
</tr>
<tr>
<td></td>
<td>• Describe pregnancy and preventing it in sexual violence survivors.</td>
</tr>
<tr>
<td></td>
<td>• Discuss using hepatitis B and tetanus toxoid vaccines with survivors of sexual violence.</td>
</tr>
<tr>
<td></td>
<td>• Explain how to prevent sexually transmitted and reproductive tract infections.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key points</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Survivors with severe and life-threatening injuries need to be referred immediately for emergency care.</td>
</tr>
<tr>
<td></td>
<td>• For severe injuries, such as high vaginal vault, anal or oral tears, survivors should be assessed by a gynaecologist or other qualified health care provider and treated.</td>
</tr>
<tr>
<td></td>
<td>• Where feasible, cases involving children should be assessed and managed by a paediatrician, gynaecologist or surgeon.</td>
</tr>
<tr>
<td></td>
<td>• Give analgesics to relieve pain.</td>
</tr>
<tr>
<td></td>
<td>• Any wounds should be cleaned and treated as necessary.</td>
</tr>
<tr>
<td></td>
<td>• Suture clean wounds within 24 hours.</td>
</tr>
<tr>
<td></td>
<td>• Give appropriate antibiotics.</td>
</tr>
</tbody>
</table>
### 2.1: Treating physical injuries

**Method**
The wider group gives suggestions on what to do with physical injuries.

- Clean and treat any wounds.
- Suture clean wounds within 24 hours.
- Do not suture dirty wounds.
- Give appropriate antibiotics and painkillers.

### 2.2: HIV transmission and rape and sexual violence

**Method**
The participants should be separated into three groups to discuss

- When does the HIV virus establish itself in the body after an exposure?
- What is the risk of infection with sexual violence?
- Who are vulnerable to HIV infection?

**Key points**

- Post-exposure prophylaxis should be given within 72 hours after the assault.
- A baseline HIV test needs to be done within 3 days, though this should not delay the first dose of post-exposure prophylaxis. Post-exposure prophylaxis should not be continued if the patient’s HIV status remains undetermined for 3 days.
- Counselling services should be offered before and after the HIV test.
- Liver function tests need to be done while using post-exposure prophylaxis.
- The full dose of post-exposure prophylaxis, a 28-day dose, should not be given. Give the prophylaxis for 14 days to facilitate counselling and monitor the client for adherence.
- In case the survivor is HIV negative at baseline, a repeat test needs to be done at 6, 12 and 24 weeks.
- For survivors who test positive, stop post-exposure prophylaxis and refer to the patient to the comprehensive care clinic for antiretroviral treatment.
Post-exposure prophylaxis regimen

AZT 300 mg + 3TC 150 mg or D4T 40 mg (30 mg if weight < 60 kg) + 3TC 150 mg twice a day for 28 days.

or

**AZT + 3TC**
Zidovudine: 300mg
+ Lamivudine: 150mg

Twice a day for 28 days

**D4T + 3TC**
Stavudine: 40mg*
+ Lamivudine: 150mg

Twice a day for 28 days

Children

- Children > 25 kg: treat as adults
- Children 15–24 kg: (+ / – syrup) AZT 200 mg BD + 3TC 75 mg BD
- Children 10–14 kg: syrup AZT 100 mg TDS + syrup 3TC 75 mg BD

2.3 : Preventing pregnancy

<table>
<thead>
<tr>
<th>Method 1</th>
<th>In small groups, participants list the emergency contraceptives they use and which combinations they give to sexual violence survivors as emergency contraceptives.</th>
</tr>
</thead>
</table>

or

<table>
<thead>
<tr>
<th>Method 2</th>
<th>Give a short lecture on the criteria for administering emergency contraceptives and what information should be given to the client with a confirmed pregnancy. The class can also discuss how to establish who is eligible for emergency contraceptives.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Handout</th>
<th>National Guidelines on Medical Management of Rape and Sexual Violence (2004) (see References)</th>
</tr>
</thead>
</table>

| Key points | • Emergency contraceptives are not 100% effective.  
            | • The sooner they are taken, within 120 hours, the more effective they are.  
            | • They do not cause abortion but prevent or delay ovulation, block fertilization, or prevent implanting the ovum. |
|------------|-----------------------------------------------------------------------------------------------|

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Emergency contraceptives should be given if the woman is not covered by a reliable contraceptive.

The survivor chooses whether or not to take emergency contraceptives.

Emergency contraception should cover all girls who have started menstruating or show secondary sexual characteristics.

If the survivor is a child who has reached menarche, discuss emergency contraception with her and her parent or guardian.

The survivor needs to be given information to decide whether to terminate the pregnancy, keep the child or give up the infant for adoption.

There is no contraindication to giving emergency contraceptives at the same time as antibiotics for STIs and HIV post-exposure prophylaxis, though the care provider should consider pill burden.

Serious side effects with emergency contraceptives are rare.

An anti-emetic should be offered with emergency contraceptives to reduce the chance of vomiting.

A pregnancy test needs to be done before prescribing emergency contraceptives to rule out pregnancy before the sexual assault and also after 6 weeks.

Emergency contraceptive regimen

Postinor 2

Two tablets in a single dose

or

Eugynon or Neogynon

Two tablets as soon as possible, then repeat after 12 hours

or

Microgynon or Nordette

Four tablets as soon as possible, then repeat after 12 hours
2.4 Sexual reproductive tract infections

<table>
<thead>
<tr>
<th>Method</th>
<th>Participants, in three groups, discuss and then present to the whole class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Infection risk and common infections</td>
</tr>
<tr>
<td></td>
<td>• The STI a rape survivor is likely to contract</td>
</tr>
<tr>
<td></td>
<td>• STI treatment and prevention</td>
</tr>
</tbody>
</table>

| Key point            | Reproductive tract infection prophylaxis should be offered to all rape survivors, but it need not be given at the same time as the initial post-exposure prophylaxis and emergency contraception, since the pill burden can be intolerable. It should be prescribed for the client and be taken within 24 hours. |

<table>
<thead>
<tr>
<th>Pregnant adults</th>
<th>Spectinomycin 2g Stat or Amoxicillin 3g Stat + Probenicid 1g Stat and Erythromycin 500mg QDS one week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-pregnant adults</td>
<td>Norfloxacin 800mg Stat + Doxycycline 100mg BD one week</td>
</tr>
<tr>
<td>(male &amp; female)</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Children</td>
<td>Amoxicillin 15mg/kg TDS on week + Erythromycin 10mg/kg QDS one week</td>
</tr>
</tbody>
</table>
### 2.5 Preventing hepatitis B

<table>
<thead>
<tr>
<th>Method</th>
<th>Give a lecture on what hepatitis B is and the need to prevent it after sexual violence.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Key points</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hepatitis B is a sexually transmitted disease found in semen, vaginal secretions, blood and saliva.</td>
</tr>
<tr>
<td>• Hepatitis B is the only sexually transmitted disease that can be effectively prevented by vaccination.</td>
</tr>
<tr>
<td>• The generally available hepatitis B vaccines do not provide protection if given after exposure, such as sexual assault, but do provide protection from future exposure.</td>
</tr>
<tr>
<td>• Administration of the toxoid (a toxoid directly neutralizes the infection), however, provides some protection after the exposure.</td>
</tr>
<tr>
<td>• If hepatitis B toxoid is available it should be considered for survivors of sexual violence.</td>
</tr>
<tr>
<td>• The vaccine is safe for pregnant women and people who have chronic or a past hepatitis B infection and can be given at the same time as the tetanus vaccine.</td>
</tr>
</tbody>
</table>

### 2.6 Tetanus toxoid

<table>
<thead>
<tr>
<th>Method</th>
<th>Give a short lecture on the administration and importance of a tetanus toxoid.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Key points</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tetanus toxoid is derived from the toxin released by the bacterium that causes tetanus.</td>
</tr>
<tr>
<td>• It is used as a vaccine to prevent tetanus or to help boost the immune response for other vaccines.</td>
</tr>
<tr>
<td>• A tetanus toxoid shot is required only if there are open wounds and if the survivor has not had a tetanus vaccine within 5 years.</td>
</tr>
<tr>
<td>• Tetanus toxoid 0.5 ml should be given for any physical injury resulting in broken skin.</td>
</tr>
</tbody>
</table>
UNIT 3: Forensic examination and collecting specimens

<table>
<thead>
<tr>
<th>Duration</th>
<th>120 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>By the end of the session participants will be able to.</td>
</tr>
<tr>
<td>- Define forensic examination.</td>
<td></td>
</tr>
<tr>
<td>- Describe informed consent.</td>
<td></td>
</tr>
<tr>
<td>- State how to obtain consent.</td>
<td></td>
</tr>
<tr>
<td>- Describe forensic examination procedures.</td>
<td></td>
</tr>
<tr>
<td>- Discuss issues related to caring for children survivors.</td>
<td></td>
</tr>
<tr>
<td>- Discuss collecting and analysing specimens.</td>
<td></td>
</tr>
<tr>
<td>- Describe the chain of custody for evidence.</td>
<td></td>
</tr>
<tr>
<td>- Demonstrate how to perform a forensic examination and document findings on the post-rape care form.</td>
<td></td>
</tr>
</tbody>
</table>

3.1 Description of forensic examination

<table>
<thead>
<tr>
<th>Method</th>
<th>Give a short lecture describing a forensic examination.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning</td>
<td>forensic medical examination</td>
</tr>
<tr>
<td>A forensic medical examination in the context of sexual violence is an examination provided to a sexual assault survivor by medical personnel trained to gather evidence after a sexual assault in a manner suitable for use in a court of law.</td>
<td></td>
</tr>
<tr>
<td>The examination should include, at a minimum,</td>
<td></td>
</tr>
<tr>
<td>- examining physical trauma</td>
<td></td>
</tr>
<tr>
<td>- determining penetration or force</td>
<td></td>
</tr>
<tr>
<td>- collecting and evaluating evidence</td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>An audiovisual presentation on forensic examination.</td>
</tr>
</tbody>
</table>
### 3.2 Describing informed consent

<table>
<thead>
<tr>
<th>Method</th>
<th>Ask for definitions about what informed consent means, then give a lecture to clarify any point that may arise.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>informed consent</td>
</tr>
<tr>
<td></td>
<td>‘Informed consent’ is when the health care provider has explained the medical procedure to the survivor so the survivor can make a decision whether to continue with the procedure or not. Informed consent is central in medical and legal matters. If a person is examined without consent the medical officer could be charged with assault, or trespass and the examination cannot be used in legal proceedings. <strong>Obtaining consent helps develop the patient’s trust and also returns a sense of control to the survivor.</strong></td>
</tr>
<tr>
<td><strong>Learning points</strong></td>
<td>• Obtain consent when there is a legal obligation to report the incident to authorities.</td>
</tr>
<tr>
<td></td>
<td>• Obtain consent before a full medical examination is done.</td>
</tr>
<tr>
<td></td>
<td>• Be sure the survivor understands the choices available and is given sufficient information to make an informed decision.</td>
</tr>
<tr>
<td></td>
<td>• Have parents, guardians, or accompanying adults give consent for children.</td>
</tr>
<tr>
<td></td>
<td>• Have the survivor sign given documents.</td>
</tr>
</tbody>
</table>

### 3.3 Obtaining consent

- Before assessing a survivor of sexual violence
  - Listen.
  - Allow the patient time to express emotions, such as crying.
  - Treat the patient with respect and compassion.
• Do not be indifferent or blame the patient for the situation.
• Remember, health care provider actions and words influence a patient, such as providing relief and comfort.

During patient assessment the health care provider should
• Assess for immediate danger, such as suicide, homicide, and needing shelter.
• Provide appropriate care.
• Document the patient’s condition.
• Help the patient develop a safety plan.
• Inform the patient of their rights.
• Refer the patient when appropriate.

During the assessment avoid
• Violating patient confidentiality by discussing the issue with colleagues or calling police without the patient’s consent.
• Trivializing or minimizing the violence.
• Blaming the survivor.
• Not respecting patient autonomy by prescribing shelter.
• Normalizing victimization by suggesting ‘many women are being raped these days’.

3.4 Examinations

Method 1

The group offers brief suggestions on the physical and forensic examinations the survivor will have to undergo, who does them, and how important they are in the context of managing survivors of sexual violence.

or

Method 2

Give an illustrated lecture, practical demonstration and discussion:
• Type of history to be collected from the survivor(s) of the occurrence and their medical history.
• To which department is the client to report for the examination?
• Examinations to be done.
• Who does the examinations?
• How to examine children.
Key points

- The physical examination must be thorough.
- To avoid further distress and repeated examinations, the medical examination and collecting forensic evidence should, when possible, occur simultaneously.
- The survivor should be treated with respect and compassion throughout the examination.
- Examination details should be explained in advance and the survivor allowed to ask questions or to stop the examination if feeling uncomfortable.

Learning point

The main purpose of the examination is to determine what medical care should be provided. A forensic examination may help prove or disprove a connection between individuals or between individuals and objects or places. History taking, examination and good documentation provide the link between the occurrence and the survivor and between the health care and the criminal justice systems.

Content

- Before starting the physical examination, take time to explain all the procedures to the client and why they are necessary.
- Allow the patient to have another person present throughout the examination.
- Throughout the examination, inform the patient what you plan to do next and ask permission.
- Assure that the room is well lit, warm, clean and private.
- Provide privacy when the patient is undressing.
- If the patient is wearing the clothing worn during the assault and forensic evidence needs to be collected, have the patient undress over a white sheet or large piece of light paper.
- Collect both medical and forensic specimens during the examination, at the same time, in the same place and by the same person, to reduce the number of examinations the survivor has to undergo.
- The health care provider is to document all findings as the physical examination proceeds.
- Make sure the patient understands that they can stop the procedure at any stage if it is uncomfortable; give the patient ample opportunity to stop the examination if necessary.
Always address patient questions and concerns in a non-judgemental, empathetic manner.

Adapted from Guidelines for Medico-Legal Care for Victims of Sexual Violence (Geneva: WHO 2003)

Content

The following procedures are guidelines for managing sexual violence survivors at primary health care facilities and provincial hospitals.

Table 1. Progotal for examining rape survivoros: managing sexual violence survivors at health care facilities

1. All survivors must be interviewed by a clinic sister-in-charge, hospital medical officer or gynaecology registrar.
2. No survivor may be turned away and made to seek help elsewhere.
3. All survivors must be seen in a private room.
4. Establish whether the rape was reported to the police.
5. If not reported, the advantages and disadvantages of reporting must be discussed with the survivor, so the survivor can decide whether to report the assault or not.
6. If the patient wishes to report the assault, the relevant police station must be contacted and a police officer requested to come to the clinic or hospital to take a statement from the survivor and collect the specimens. If the survivor does not wish to report the matter to the police, a full forensic examination should still be done with the patient’s consent, in case the survivor decides to report the rape later.
7. If a crisis centre exists in the area and the patient so wishes, the patient should be transferred to the centre for examination and treatment.
8. If the survivor is not referred to a crisis centre, the forensic and medical examinations and treatment must be done by a trained nurse, clinical officer or a doctor.
9. The examination and treatment should not be delayed unduly, even if the police are unable to come to the clinic within a short time, so evidence is not lost and treatment can begin.
10. The health care provider must obtain informed consent for the general medical examination and treatment and a separate consent for the forensic examination and testing, and an HIV test. A survivor may decline a forensic examination and the choice must be respected.
11. The forensic examination results must be recorded on a P3 form and an exhibit memo form completed.
12. All specimens taken should be sealed, labelled and kept safe until handed over to the police, if the survivor wishes to lay a complaint. Take care to ensure chain of custody for the specimens.
Components of a sexual violence survivor clinical examination

Most clinical examinations of rape survivors have five components.

Table 2. Components of a sexual violence survivor clinical examination

<table>
<thead>
<tr>
<th>Component</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Treat, document and evaluate injuries</td>
<td>Examine and treat, following protocols</td>
</tr>
<tr>
<td>2. Collect forensic evidence</td>
<td>Collect swabs, clothing, comb hair, nail clippings</td>
</tr>
<tr>
<td>3. Evaluate for and treat sexually transmitted diseases</td>
<td>Prescribe preventive drugs and sample blood for possible sexually transmitted diseases, such as HIV and syphilis</td>
</tr>
<tr>
<td>4. Evaluate pregnancy risk and prevent pregnancy</td>
<td>May offer pill to prevent pregnancy, if patient is of child-bearing age and not using contraceptives</td>
</tr>
<tr>
<td>5. Counsel for crisis intervention and follow it up</td>
<td>Patient can go to post-trauma counselling in any health facility that provides it</td>
</tr>
</tbody>
</table>

Adapted from Concise Text and Manual of Forensic Medicine, Medical Law and Ethics in East Africa (Nairobi: Independent Medico-Legal Unit 2005)

3.5 Caring for child survivors

<table>
<thead>
<tr>
<th>Method</th>
<th>Give a short lecture on handling child survivors.</th>
</tr>
</thead>
</table>

| Key point                                  | Health care providers should know about child development and growth as well as child anatomy. |

Content

Create a safe and trusting environment

- Introduce yourself to the child.
- Sit at eye level and maintain eye contact.
- Assure the child that they are not in any trouble.
- Ask a few questions about neutral topics, such as school, friends, who they live with, and favourite activities.
- Take special care to determine who should be present during the interview and examination. (Remember, a family member could be the perpetrator.) The child’s
parent or guardian may wish to be present. Ask the child if it is all right to do the examination while the parent or guardian waits outside. Respect the child’s wishes. The child may wish to have another support person during the interview and examination. Do not hesitate to refer the child for specialized counselling support if required.

Take the history

- Begin the interview by asking open-ended questions, such as ‘Why are you here today?’ or ‘What were you told about coming here?’
- Assure the child it is all right to respond to any question with ‘I don’t know’.
- Be patient, go at the child’s pace, and do not interrupt the child’s train of thought.
- Ask open-ended questions to get information about the incident. Ask yes or no questions only to clarify details.
- The dynamics of the sexual abuse in children is often different from adult abuse. For example, it is often repeated. To get a clearer picture of what happened, try to obtain information on
  - the home situation (does the child have a secure place to return to?)
  - how the rape or abuse was discovered?
  - the number of incidents and date of the last incident

Prepare the child for examination

As with adult examinations, there should be a support person or trained health worker the same sex as the survivor in the examining room with the examiner.

- Encourage the child to ask questions about anything uncertain or not understood any time during the examination.
- Explain what will happen during the exam, in language a child can understand.
- With adequate preparation, most children will relax. If in doubt, give paracetamol or other simple painkiller to relieve pain. Wait for it to take effect.
- Never restrain or force a frightened, resistant child to complete an exam. Restraint and force are often part of sexual abuse; if used by those attempting to help, it will only heighten the child’s fear and anxiety and worsen the psychological effect of the abuse.

Adapted from Clinical Management of Rape Survivors (Genova: WHO 2006)

3.6 Specimen collection

| Method | The whole group discusses the specimens to be collected, the reasons behind them and precautions. A forensic expert will clarify any problems. |

28 / clinical care for survivors of sexual violence
Key point

Health care providers should prevent cross-contamination of all specimens and ensure specimens are properly collected and stored.

Learning point

Health care providers should be aware of the capabilities of their laboratory to avoid collecting specimens that cannot be tested. Forensic evidence may be used to support a survivor’s story, confirm recent sexual contact, show contact, show that force or coercion was used and, possibly, identify the perpetrator. Properly collecting and storing specimens and evidence is key to aiding the survivor pursue legal redress.

Content

Table 3. Usual forensic examination specimens for sexual violence and purposes for taking them

<table>
<thead>
<tr>
<th>Specimen</th>
<th>Test for</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clothing</td>
<td>Stains, foreign materials, tears</td>
<td>Identify assailant through blood or saliva</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Show torn clothing as evidence of force</td>
</tr>
<tr>
<td>Semen (sperm)</td>
<td>Blood group, assailant DNA and proteins in semen (PSA 2 or p30)</td>
<td>Identify assailant</td>
</tr>
<tr>
<td>Blood</td>
<td>DNA, alcohol or drugs</td>
<td>Identify assailant and survivor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ability of survivor to consent</td>
</tr>
<tr>
<td>Saliva</td>
<td>Blood group</td>
<td>Identify assailant</td>
</tr>
<tr>
<td>Urine</td>
<td>Alcohol and drugs</td>
<td>Ability of survivor to consent</td>
</tr>
<tr>
<td>Pubic or head hair</td>
<td>DNA</td>
<td>Identify assailant and survivor</td>
</tr>
<tr>
<td>Foreign fibres, grass, soil</td>
<td>Fibres found at incident site</td>
<td>Verify claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Link assailant to scene</td>
</tr>
<tr>
<td>Fingernail scrapings or clippings</td>
<td>DNA</td>
<td>Identify assailant</td>
</tr>
</tbody>
</table>

Adapted from *Concise Text and Manual of Forensic Medicine, Medical Law and Ethics in East Africa (Nairobi: Independent Medico-Legal Unit in Nairobi, 2005)*
3.7 Evidence chain of custody

<table>
<thead>
<tr>
<th>Method</th>
<th>Divide the participants in two groups to discuss</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• A woman, man or child comes to you after being raped. What will you do?</td>
</tr>
<tr>
<td></td>
<td>• How are you supposed to handle the collected evidence?</td>
</tr>
<tr>
<td></td>
<td>The facilitator gives a lecture on the procedures to maintain chain of custody for evidence.</td>
</tr>
</tbody>
</table>

| Learning point | It is important to maintain the chain of evidence, at all times, to ensure the evidence will be admissible in court. |

Content

- Collected evidence should be labelled, stored and transported properly.
- Documents must include a signature of everyone who possessed the evidence, at any time, to prevent tampering.
- If it is not possible to bring the samples immediately to a laboratory, precautions must be taken:
  - All clothing, swabs, gauze and other objects to be analysed need to be well dried at room temperature and packed in paper, not plastic, bags. Samples can be tested for DNA many years after the incident, if the material is well dried.
  - Blood and urine samples can be stored in the refrigerator 5 days. To keep the samples longer, they need to be stored in a freezer.
  - All samples should be clearly labelled with a confidential identifying code (not the name of the survivor), date, time, what it is, location it was taken and put in a container.
  - Seal the bag or container with paper tape across the closure and write the identifying code, the date and sign your initials across the tape.
  - Clearly write the laboratory’s instructions for collecting, storing, and transporting samples.

Adapted from *Clinical Management of Rape Survivors: A Guide to Assist in the Development of Situation Specific Protocols* (Geneva: WHO 2002b)

Note: Evidence should be released to the authorities only if the survivor decides to proceed with a case. The survivor may consent to have the evidence collected, but not have the evidence released to the authorities at the time of the examination.
3.8 Documentation

<table>
<thead>
<tr>
<th>Method</th>
<th>Give a short lecture on the documents to be kept.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>PRC 1 and PRC 2 forms (annexes 5 and 6)</td>
</tr>
<tr>
<td></td>
<td>Issues to be considered</td>
</tr>
<tr>
<td></td>
<td>• Who fills out the PRC 1 form?</td>
</tr>
<tr>
<td></td>
<td>• Importance of written test results</td>
</tr>
<tr>
<td></td>
<td>• Importance of documentation</td>
</tr>
<tr>
<td></td>
<td>• Record keeping, who fills in the documents and where the documents are stored.</td>
</tr>
</tbody>
</table>

| Key point | Documentation must be thorough because it underlies the primary evidence and links the crime and the criminal justice system. |

| Learning point | • The PRC 1 form is to be filled out in triplicate. It allows for taking patient history, examination and subsequent filling of the P3 form. |
|               | • All findings must be documented carefully. |
|               | • The survivor should be given the PRC 1 original (white) copy, the yellow copy is attached to the P3 form as the clinical notes, and the green copy remains in the hospital record. |

Content

- Treat all with empathy and without bias.
- Take a careful and detailed history to include
  - identification by name, age, sex, marital status
  - time and date of assault and client’s presentation to the health facility
  - place of residence
  - whether the survivor bathed, urinated, defecated, vomited, douched, or changed clothes after the incident
  - next of kin or informant
  - where the assault occurred
  - where the penetration occurred, with what, with or without ejaculation
o whether the assailant was known or unknown and number assailants
o evaluation for possible pregnancy, record of last menstrual period and contraceptive use
o circumstances surrounding the event (though not important)
o type of assault
o whether condom(s) was used
o when or whether reported to the police or hospital after the assault

• Record findings on the P3 form after the survivor recovers.
• Ensure the PRC 1 form was filled out.
• Separate facts, findings and opinions.
• Look for any changes in the wound and document it.

3.9 : Demonstrate forensic examination and documentation

<table>
<thead>
<tr>
<th>Time</th>
<th>120 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method</td>
<td>Use the DVD on forensic examination to give participants a clear idea of a forensic examination.</td>
</tr>
</tbody>
</table>
## Day 2

### UNIT 4: COUNSELLING

**Duration** 120 minutes

By the end of the session participants will be able to
- Describe counselling and its purpose.
- Discuss the counselling required in post-rape management.
- Explain how counselling and clinical care intersect.
- Discuss debriefing for medical care personnel.

### 4.1 What counselling entails

<table>
<thead>
<tr>
<th>Method 1</th>
<th>In a group, let the participants share</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What is counselling?</td>
</tr>
<tr>
<td></td>
<td>• Why it is needed in the context of sexual violence.</td>
</tr>
<tr>
<td></td>
<td>• What some of the issues are, about which the survivor needs to be counselled.</td>
</tr>
<tr>
<td></td>
<td>• Why clients need to be referred for counselling.</td>
</tr>
</tbody>
</table>

| Method 2 | Divide participants into groups of three. Provide different short case studies of people who have been sexually violated. Ask participants to read the case studies and identify issues and concerns the survivors have. Discussions should concern the effects of sexual violence on the survivor and survivor’s family. |

| Material | Real cases (annex 7). |

The health care worker needs to refer the survivor to appropriate counselling.

| Key point | Most sexual violence survivors never tell anyone about the incident. If a survivor tells you what happened, it is a sign of trust. All survivors need to be referred for trauma counselling. Although trauma symptoms might not occur or disappear, all survivors should be referred for counselling. The health care provider must aim for |
an attitude of respect, empathy and be non-judgemental while the survivor recounts the experience. Most survivors will not remember the information given them during their first visit; it is important to repeat this information during follow-up visits.

Content

Counselling is a structured conversation between two or more people that helps a participant work through particular problems or conflicts and feelings and helps find ways to resolve or cope with them. Counsellors encourage people to recognize and develop their own coping capacity, so they can deal more effectively with problems.

While the term ‘counselling’ may be unfamiliar to some, the behaviour is probably common in all cultures. Counselling not only helps people with their immediate problems, it also helps them to recognize and draw upon their own resources, which they can use for future problems.

Counselling is about creating new perspectives and change. Counselling may help the person feel differently about a situation; change their behaviour, for example, practise safer sex; or change something in their environment, for example, set up a support group.

Counselling aims to help people

- Understand their situation more clearly;
- Identify choices for improving the situation;
- Make choices that fit their values, feelings and needs;
- Make their own decision and act on it;
- Cope better with a problem;
- Develop life skills, such as being able to talk about sex with a partner; and
- Provide support for others while preserving their own strength.

Note: Clinicians often ignore counselling, thus affecting post-exposure prophylaxis and client return rate for clinical evaluation and management. Clinicians should not do intensive counselling, but the initial contact with the survivor requires counselling skills. Clinicians must refer the patient to counsellors and emphasize the need for counselling.

Content

Very often after sexual violence has happened, people will say things such as ‘It’s over now, you must get on with the rest of your life’. Or they will not understand why, after
six months, the survivor is still suffering from the effects of rape. Sexual violence only begins with the physical act, during which every survivor is concentrated on surviving. After the assault, the struggle to comprehend what has happened begins. The violation floods over the survivor, but the survivor has to find the way to return to life, body and self.

Sexual violence is as much a destruction of ‘self’ as it is a physical invasion. The battle between ‘mind rape’ and the will to find self again is called ‘survival’.

‘Trauma syndrome’ is the medical term for the response survivors have to rape and similar traumatic stress disorders.

- shock: feeling cold, faint, disoriented, nauseous and sometimes vomiting and trembling
- irregular, heavier or painful periods; vaginal discharge; bladder and reproductive tract infections
- bleeding or infections from tears or cuts in the vagina or rectum
- sore body, bruises, grazes and cuts
- nausea with or without vomiting
- throat irritations or soreness from forced oral sex
- tension headaches
- pain in the lower back and stomach
- insomnia, exhaustion and need for more sleep than usual
- not eating, eating less or needing to eat more than usual

- crying more than usual
- difficulty concentrating
- restless, agitated and unable to relax or listless and unmotivated
- not wanting to socialize or see anybody or socializing more than usual to fill up every minute of the day
- not wanting to be alone
- stuttering or stammering more than usual
- avoiding anything that reminds of the rape
- more easily frightened or startled than usual
- very alert and watchful
- easily upset by small things
• problems with family, friends, lovers and spouses from irritability, withdrawal and dependence
• fearing sex, losing interest in sex or losing sexual pleasure
• changing lifestyle
• increasing drug and alcohol use
• increasing washing or bathing
• denying the rape by behaving as if the rape did not occur and trying to live life as it was before the rape
• taking sexual risks

• increased fear and anxiety
• self-blame and guilt
• helplessness and no longer feeling in control of life
• humiliation and shame
• lowered esteem and feeling dirty
• anger
• feeling alone and that no one understands
• hopelessness
• emotional numbness
• confusion
• memory loss
• constantly thinking about the sexual assault
• rape flashbacks and feeling it happen again
• nightmares
• depression
• suicidal tendencies
• homicide, suicide and AIDS death

The manner survivors of sexual violence cope and the time symptoms are present are influenced by
• support system
• the relationship with the offender
• the violence used
• social and cultural influences

36 / Clinical Care for Survivors of Sexual Violence
Almost all rape survivors suffer severe and long lasting psychological trauma. Sexual assault appears to be a combination of features.

- It is sudden.
- It is perceived as life threatening.
- It violates the survivor’s physical and psychological integrity and renders the survivor helpless.
- The survivor is forced to participate.
- The survivor cannot prevent the assault or control the assailant; normal coping strategies failed.
- The survivor is a victim of rage and aggression.

The trauma is usually compounded by the myths, prejudice and stigma associated with rape. Survivors who believe these myths fight feelings of guilt and shame. The burden can be overwhelming, especially if other people reinforce the myths and prejudices. This makes it essential that all legal, medical and police procedures must not cause survivors further trauma and must give all possible support, so the survivor can overcome and survive the ordeal.

### 4.2 Types of counselling

<table>
<thead>
<tr>
<th>Method 1</th>
<th>Give a short lecture on</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>the need for HIV pre-test and post-test counselling</td>
</tr>
<tr>
<td></td>
<td>importance of counselling on adherence to post-exposure prophylaxis</td>
</tr>
<tr>
<td></td>
<td>importance of psychological trauma counselling</td>
</tr>
<tr>
<td></td>
<td>who offers counselling, where is it offered and by whom</td>
</tr>
<tr>
<td></td>
<td>counselling for special cases</td>
</tr>
</tbody>
</table>

or
### Method 2

Discuss with the groups what to consider when preparing a survivor for an HIV test. The survivor is still traumatized. The health worker has to be sensitive when introducing the survivor to an HIV test because

- The survivor may have never had an HIV test.
- The survivor is still processing the ordeal.
- The survivor fears the results.
- The survivor may not have disclosed the assault to the partner or family.
- The client may have a different understanding of what an HIV test result means.

### The facilitator also needs to stress that health providers should refer the patient to receive

- crisis management counselling
- timely sexual violence HIV pre-test and post-test counselling with risk assessment from previous consensual exposures, HIV-positive status at baseline and need for links with HIV care and antiretroviral treatment
- counselling to support survivor adhering to post-exposure prophylaxis
- counselling to deal with pregnancy
- counselling for disclosure of sexual violence and of HIV status
- counselling to prepare client for the criminal justice system
- counselling children and their parents and guardians

### Key message

Health workers cannot offer intensive counselling to all their patients. They need to refer sexual violence survivors to trained rape trauma counsellors for psychological support.

The survivors need to be referred to counsellors as soon as they have been given the first post-exposure prophylaxis and emergency contraceptive doses for counselling on the HIV test.

Clinicians can provide basic counselling to survivors before doing the forensic examination and offer prophylaxis, then refer the survivor for further counselling.
In addition to psychological trauma, counselling is required for issues directly related to clinical care:

- counselling to help clients understand the necessity for often painful and embarrassing examination and documentation
- discussion on concerns and options for pregnancy that may not be addressed by clinicians
- counselling for HIV testing
- counselling for adhering to post-exposure prophylaxis, even though side effects of treatment and trauma syndrome interact

Rape force and tears help infect the survivor with HIV, but not all survivors will get infected after a sexual assault.

### 4.3 Intersecting counselling and clinical care

**Method**

Ask participants to discuss the links they see emerging between clinical care and counselling services. This can be done in groups or in plenary.

**Content**

**HIV pre-test and post-test counselling**

HIV pre-test and post-test counselling understands that HIV testing is difficult and is a prerequisite for post-exposure prophylaxis.

- Survivor pre-test counselling includes a sexual risk assessment for possible HIV infection before the violent incident.
  - This should be offered by a trained rape trauma counsellor.
  - The counsellor refers the client to the laboratory for an HIV test.
- Post-test counselling includes delivering the results.
  - The counsellor collects the results from the lab on the survivor’s behalf.
The counsellor provides information on HIV post-exposure prophylaxis, how the drugs work and their limitations. Possible seroconversion is stressed. Its implications, even when the survivor is on post-exposure prophylaxis, are discussed.

4.4 Counselling children

<table>
<thead>
<tr>
<th>Method</th>
<th>The group offers brief suggestions on how health care workers should handle children who have been sexually violated.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key point</td>
<td>Survivors should be referred to counsellors trained in counselling for sexual violence trauma, HIV testing and post-exposure prophylaxis adherence with skills in providing support for children.</td>
</tr>
</tbody>
</table>

Content

Table 4. Tips for counselling an abused child

<table>
<thead>
<tr>
<th>DO'S</th>
<th>DON'TS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Believe the child</td>
<td>Do not ask accusing questions</td>
</tr>
<tr>
<td>Create rapport with the child</td>
<td>Do not be overly informal</td>
</tr>
<tr>
<td>Show some trust</td>
<td>Do not be judgemental</td>
</tr>
<tr>
<td>Let the child relate to you as a fellow human being</td>
<td>Don’t be impersonal, but keep a professional distance</td>
</tr>
<tr>
<td>Be accessible and reliable</td>
<td>Do not miss appointments, read or talk on the phone when the child is talking to you</td>
</tr>
<tr>
<td>Assure the child a reasonable confidentiality</td>
<td>Do not give information about the child unless professionally required</td>
</tr>
<tr>
<td>Be realistic and explain circumstances as they are likely to happen</td>
<td>Do not assure the child about matters you have no control over</td>
</tr>
<tr>
<td>Exhibit professionalism</td>
<td>Do not be too personal or create a dependency</td>
</tr>
<tr>
<td>Ensure privacy so the child can talk in confidence</td>
<td>Do not interview in an open space with likely interruptions</td>
</tr>
<tr>
<td>Agree at the onset on the amount of time you will take</td>
<td>Do not appear to be in a hurry</td>
</tr>
<tr>
<td>Keep proper physical space</td>
<td>Do not hug and peck, especially if you are of the opposite sex</td>
</tr>
<tr>
<td><strong>DO’S</strong></td>
<td><strong>DON'TS</strong></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Be sensitive to any reactions from the child</td>
<td>Do not react negatively to any negative reaction</td>
</tr>
<tr>
<td>Empathize . . .</td>
<td>Not sympathize</td>
</tr>
<tr>
<td>Assure the child can always come back</td>
<td>Do not feel frustrated that the child does not open up</td>
</tr>
<tr>
<td>Control your emotions</td>
<td>Do not break down</td>
</tr>
<tr>
<td>Patiently let the child go at own pace and listen carefully and with understanding</td>
<td>Do not pressure the child to speak or rush the child</td>
</tr>
<tr>
<td>Be wise, warm and sensitive</td>
<td>Do not keep interrupting</td>
</tr>
<tr>
<td>Evaluate your own thoughts and behaviour</td>
<td>Do not project or transpose personal experience</td>
</tr>
<tr>
<td>Accept the child as is</td>
<td>Do not be judgemental</td>
</tr>
<tr>
<td>Be impartial and objective</td>
<td>Do not mislead</td>
</tr>
<tr>
<td>Be knowledgeable</td>
<td>Ignorance or lack of understanding child behaviour may not help counselling</td>
</tr>
<tr>
<td>Create a relaxed atmosphere</td>
<td>Do not go where the child feels the need to leave as soon as possible</td>
</tr>
<tr>
<td>Show commitment</td>
<td>If you are not able to be committed, do not offer assistance</td>
</tr>
</tbody>
</table>

Be realistic and know when your competence or assistance is no longer useful:
- a case of insanity
- a personal clash
- a relative or friend
- not making any headway
- issue needs legal assistance not counselling
- attracted to the client
- the person is suicidal

Then refer, with the consent of the child or guardian

Adapted from *Making Schools a Safe Horizon for Girls* (2004)
UNIT 5: Referral mechanisms

<table>
<thead>
<tr>
<th>Duration</th>
<th>120 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>By the end of the session participants will be able to</td>
<td></td>
</tr>
<tr>
<td>* Discuss client flow for post-rape care services for the institution.</td>
<td></td>
</tr>
<tr>
<td>* Identify referral agencies to support the survivors and their families.</td>
<td></td>
</tr>
<tr>
<td>* Explain the internal and external reporting mechanisms.</td>
<td></td>
</tr>
<tr>
<td>* Understand the referral systems in health facilities.</td>
<td></td>
</tr>
</tbody>
</table>

5.1 Client flow for post-rape care services for the institution

<table>
<thead>
<tr>
<th>Method</th>
<th>The group discusses client flow of post-rape care within their institutions:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>* the main challenges in the health care facility</td>
</tr>
<tr>
<td></td>
<td>* how they address the challenges</td>
</tr>
<tr>
<td></td>
<td>* the most appropriate referral system for their facility</td>
</tr>
</tbody>
</table>

Figure 1. Post-rape care algorithm.

Survivor

CASUALTY or OUTPATIENT
Emergency management
Post-exposure prophylaxis, emergency contraceptive, clinical evaluation and documentation, PRC1

Counselling, primarily at voluntary counseling and testing clinics
Trauma and crisis, HIV testing, post-exposure prophylaxis adherence; preparation for justice system

Laboratory
HIV testing, blood monitoring (Hb), specimen analysis

On-going follow up at 2/52 and 4/52

Refer to STI clinic if care not provided at HIV and antiretroviral care clinic

HIV and antiretroviral care clinic:
Follow up with post-exposure prophylaxis
PRC 2 form: HIV status, age, weight, sex, Laboratory monitoring, post-exposure prophylaxis results
5.2 External referral agencies for supporting survivors and their families

| Method | Participants list agencies around their health facilities where they can refer sexual violence survivors. Participants also list agencies where post-exposure prophylaxis is offered and those with long-term counselling. The session can end with group presentations and discussions on referral mechanisms and services available for survivors and their families. |

5.3 Internal and external reporting mechanisms

| Method | The group discusses

- the medical records kept in different health facilities and the reporting mechanism used (both internal records and those forwarded to the next level of health facilities)
- how to identify a suitable facility to refer clients for further clinical management or counselling |

5.4 Referral system

| Method | In pairs, the participants

- Define a referral system.
- List the different referrals.
- Describe the importance of referral system in post-rape care.
- Describe referral components.
- Identify resources for a good referral system.
- Explain the community role in the referral system. |

Participants offer short definitions of referral and the different types. The facilitator clarifies the definition and types.

| Key point | Establishing and strengthening existing internal referral systems will improve post-rape care. |
Content

Definition: referral mechanism
‘Referral mechanism’ is client transfer from a service point or community to another service or back to the community.

Referral types
- Vertical referral: a client is transferred to a higher or lower service delivery.
- Horizontal referral: the client is transferred to a similar facility because there is a temporary lack of certain services or for a second opinion.
- Consultancy referral: a client is referred for specialized care.
- Central referral: a client is referred to a central point for commonly shared services.
- Community referral: the client is referred from the community to the health facility or vice versa.

Importance of referral systems
Referral helps provide better services. When referral is appropriate and properly executed it can aid recovery, psychological and emotional support, diagnosis, treatment, and specialized care.

The community in the referral system
- Community involvement in planning, designing, developing and supporting the referral system affects its population.
- Community education gives information to understand and appreciate referral systems and participate in the referral
- Community participation may provide finances and transport, give feedback, accept clients back into the community and promote referral.

Referral components
- problem identification
- problem assessment
- problem diagnosis
- referral counselling
- communication
- transfer
- facility feedback
- community feedback
**Unit 6: Registration and information management**

Registration and information management is premised on trainees assessing the registration and functioning of registered post-rape care facilities.

<table>
<thead>
<tr>
<th>Duration</th>
<th>150 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>By the end of the session participants will be able to</td>
</tr>
<tr>
<td></td>
<td>• Establish the procedure for registering a post-rape care site</td>
</tr>
<tr>
<td></td>
<td>• Establish the minimum requirements for comprehensive post-rape care in health facilities</td>
</tr>
<tr>
<td></td>
<td>• Learn about the reporting mechanisms.</td>
</tr>
</tbody>
</table>

**6.1 Registering a post-rape care Site**

**Method**

The group will make short suggestions on what a post-rape care site should provide. Then divide the participants into two groups to list the aspects considered before a site is registered.

**Materials**

The facilitator gives a copy of the registration checklist (annex 8) to each participant and goes through it.

**Key point**

Registration is compulsory for all sites planning to provide post-rape care. The provincial or the district reproductive health training and supervision team should do a registration assessment and send the results to the Division of Reproductive Health for coding. This is to ensure compliance with minimum requirements for registration of national post-rape care services.
### 6.2 Minimum requirements for providing post-rape care services

<table>
<thead>
<tr>
<th>Method</th>
<th>Divide the participants into three groups. Assign:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Group one to discuss the minimum requirements for facilities without laboratories</td>
</tr>
<tr>
<td></td>
<td>• Group two to discuss the minimum requirements for health facilities with a laboratory</td>
</tr>
<tr>
<td></td>
<td>• Group three to discuss the minimum requirements for health facilities with HIV, antiretroviral or comprehensive care clinics where clients on antiretrovirals can be monitored.</td>
</tr>
</tbody>
</table>

The groups will present their discussions and the facilitator will add omissions and any other clarifications.

| Key point | Participants must know the post-rape care requirements to register a site. They must also know the standards that must be met by all health facilities requesting registration. |

### 6.3 Reporting mechanisms

<table>
<thead>
<tr>
<th>Method</th>
<th>The facilitator asks for short answers on existing reporting mechanisms. Discuss how post-rape care fits into these mechanisms, highlighting the effectiveness and challenges.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials</td>
<td>Provide participants with copies of and discuss the data-collecting tools.</td>
</tr>
</tbody>
</table>

| Key points | • Information of all sexual violence survivors should be entered in the post-rape care register in the casualty or outpatient department or the post-rape care clinic. |
|           | • The post-rape care forms should be accurately and completely filled in triplicate. |
|           | • The original, white, copy should be given to the survivor, the yellow copy attached to the P3 form and the green copy kept in the client file and treated as confidential. |
|           | • PRC 2 form is for long-term management and is available in facilities where post-exposure prophylaxis is offered. |
• A complete and accurate PRC 2 form is submitted to the district AIDS and STD coordinator quarterly or as necessary for more supplies.
• All emergency contraceptives issued to sexual violence survivors should be recorded in the family planning daily activity register.

Note: Post-rape care facility data will be integrated into the other routine reproductive health data and sent to the district medical records office.
Day 3

UNIT 7: Supervision for quality improvement

Duration 120 minutes

Objective Participants to share knowledge on how to improve quality of services and supervision.

Content

- Define quality and quality improvement.
- Name principles of quality improvement.
- Define facilitative supervision.
- Describe the facilitative supervisor.
- Explain the benefits of facilitative supervision.
- State the difference between traditional and new approaches to supervision.
- State the levels of supervision in Kenya.

7.1 : Quality and quality improvement

Method Facilitate a light discussion defining quality and quality improvement. The facilitator will conclude by defining the two concepts.

Definition: quality
‘Quality’, in health care is meeting the needs and expectations of clients with minimum effort, rework and waste

Definition: quality improvement
‘Quality improvement’ involves the concerted effort to continuously do things better until they are done right the first time, every time.
7.2 Quality improvement principles

<table>
<thead>
<tr>
<th>Method</th>
<th>The whole group discusses how quality in the Ministry of Health facilities and service can be improved.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key point</td>
<td>The Ministry of Health approach to quality improvement is based on the rights and needs of clients.</td>
</tr>
</tbody>
</table>

Figure 3. Quality service principles. (adapted from A New Approach to Supervision: Facilitative Supervision Manual for Supervisors of Reproductive Health Services (Nairobi: Ministry of Health, 2005)).
### 7.3 Facilitative supervision

<table>
<thead>
<tr>
<th>Method</th>
<th>Divide the class into four groups. Discuss and present to the whole group:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• definition of facilitative supervision</td>
</tr>
<tr>
<td></td>
<td>• the qualities and roles of a facilitative supervisor</td>
</tr>
<tr>
<td></td>
<td>• the benefits of facilitative supervision</td>
</tr>
<tr>
<td></td>
<td>• the difference between traditional and facilitative supervision</td>
</tr>
</tbody>
</table>

#### Content

**Definition: facilitative supervision**
‘Facilitative supervision’ is a management approach where supervisors focus on staff needs to enable the staff to incorporate quality improvement, meet their clients’ needs and implement institution goals.

**Facilitative supervision concept**
Facilitative supervision emphasizes advising, joint problem solving and communication between the supervisor and supervisee. The supervisor serves as a liaison between staff and external support.

**Facilitative supervisor qualities**
- Shows leadership by inspiring others, establishing trust and promoting work.
- Has good communication skills, especially listening and constructive feedback.
- Can empower others and promote opportunities for growth.
- Able to work in teams, secure support and be a role model.
- Is experienced in delivering reproductive health services.
- Has technical knowledge.
- Is flexible.
- Is open to new ideas.
- Is able to train and convey information to others.
- Is empathetic.

**Facilitative supervisor roles**
- Sets goals.
- Leads.
• Motivates staff.
• Links with larger system.
• Fosters trust.

**Facilitative supervision benefits**

• Staff teams solve their own problems.
• Supervisors under the facilitative supervisor learn to supervise better.
• Supervisor gains a reputation as a leader, effective supervisor and an enabler.
• System helps staff solve their problems rather than criticize their faults.
• It fosters teamwork, staff learning and growth.
• It ensures service quality.
• Staff motivation and commitment increases.

**Difference between traditional and facilitative supervision**

• Facilitative supervision
  - focuses on helping staff solve problems through quality improvement tools
  - focuses on process not individuals
  - assists staff in planning quality improvement goals
  - builds on gains while setting higher quality goals

• Traditional supervision
  - is superficial because the supervisor cannot spend enough time at the site to become familiar with problems or help solve them
  - is punitive because traditional supervisors often come and go without any staff interaction and often look for deficiencies
  - focuses on individuals, not process, and prevents staff from performing well
  - emphasizes the past rather than the future by focusing on individual performance in reports on happenings rather than plans for the future
  - lacks continuity because it is sporadic and does not build on experience

**7.4 : Levels of supervision in Kenya**

| Method | The facilitator guides the whole group on discussing the different levels of supervision in the Ministry of Health reproductive health services, including who supervises, what is supervised and who is supervised and how frequently. |

*clinical care for survivors of sexual violence / 51*
Content

Figure 4. Supervision levels in Kenya (adapted from Kenya National Reproductive Health Instructional Manual for Service Providers 2006).

UNIT 8: Monitoring and evaluation

<table>
<thead>
<tr>
<th>Time</th>
<th>120 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>By the end of this module participants should be able to</td>
</tr>
<tr>
<td></td>
<td>• Know the basic concepts of monitoring and evaluation.</td>
</tr>
<tr>
<td></td>
<td>• Describe the monitoring and evaluation types.</td>
</tr>
<tr>
<td></td>
<td>• Write steps to set up a monitoring and evaluation framework for post-rape care.</td>
</tr>
<tr>
<td></td>
<td>• Learn how to monitor and evaluate.</td>
</tr>
<tr>
<td></td>
<td>• Acquire knowledge on data quality management.</td>
</tr>
</tbody>
</table>
8.1 : Basic monitoring and evaluation

| Method                          | Facilitate short suggestions defining monitoring and evaluation, their differences and purposes. The facilitator ends the session by clarifying or adding onto what was said. |

8.2 ACTIVITY: Monitoring and evaluation types and purposes

<table>
<thead>
<tr>
<th>Method</th>
<th>Participant groups discuss</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• What do health care providers monitor and evaluate?</td>
</tr>
<tr>
<td></td>
<td>• When do they do it?</td>
</tr>
<tr>
<td></td>
<td>• Who does it?</td>
</tr>
<tr>
<td></td>
<td>• How do they do it?</td>
</tr>
<tr>
<td></td>
<td>• Why do they do it?</td>
</tr>
</tbody>
</table>

Content

Definition
• ‘Monitoring’ is the routine, daily assessment of activities toward program objectives. It routinely looks at the service quality and what was achieved.
• ‘Evaluation’ is the periodic assessment of the overall program. Social science research methods are used to investigate program’s effectiveness by examining its effect.

Monitoring and evaluation types
• ‘Formative needs assessments’ are conducted during planning or replanning the program to identify needs and resolve issues before the program is widely implemented.

Guiding questions in formative needs assessment
• Is an intervention needed?
• Who needs the intervention?
• How should the intervention be carried out?

Monitoring has three main domains:
• Inputs, which are resources for conducting and carrying out the program.
• **Process**, which are activities the human and financial resources used to achieve the program results, such as the number of training sessions. Monitoring these activities will show what, how well and how timely they were done.

• **Outputs**, which are the immediate program results and may be in three forms:
  o number of activities conducted in each area, such as training
  o access or measuring service adequacy
  o services used or measurement of extent services were used

**Guiding questions in monitoring**
• Is the program directed toward a set target?
• To what extent are planned activities realized? What services are provided, to whom, when, how often, for how long and in what?
• How well are the services provided?
• What is the quality of services provided?
• Is the program running consistently within the design?
• What is the cost for each person served?

**Evaluation**
• Accounts for what has been accomplished through project funds.
• Promotes learning in what works and what does not work.
• Provides feedback to stakeholders for decisions.
• Assesses the cost-effectiveness of the program.
• Enhances the effectiveness of project and program management.
• Contributes to policy development.

**Guiding evaluation questions**
• What: Did it do what was said it could do?
• Why: What worked and what didn’t work?
• So what: What difference did it make?
• Now what: What could be done differently?
• Then what: How to use the evaluation to continue learning?

**Cost-effectiveness analysis** helps managers and planners make decisions about their budgets and funding. It combines monitoring data and cost data to help the manager make choices about allocating funds and deciding whether or not funds are spent appropriately.
Monitoring allows a project, program or research objectives and activities to be revised early or completely overhauled, depending on the feedback. It measures the performance of the organization, person or intervention to

- ensure improvements or changes by identifying what is working as planned and what needs correction
- follow progress toward set standards

Day-to-day performance and quality monitoring should be a supervisor’s main concern.

### 8.3: Review knowledge of monitoring and evaluation

<table>
<thead>
<tr>
<th>Method</th>
<th>Give a lecture on monitoring and evaluation tools and processes. The facilitator discusses the types and use of monitoring tools. Divide the participants into three groups to discuss applying different monitoring, frequency and tools to improve post-rape care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning point</td>
<td>Monitoring enables measuring, to see if targets have been achieved.</td>
</tr>
</tbody>
</table>

- Define project objectives.

- Develop indicators to measure progress toward the objectives.

- Establish data collection systems.

- Analyse and interpret data.

- Use the evaluation to improve the program and disseminate it to stakeholders.

**Post-rape care program indicators**

An ‘indicator’ is a measurable statement program objectives and activities. An indicator set includes at least one indicator for input, output, process, outcome and effect. Indicators for monitoring and evaluating post-rape care be

- **Valid**: they are something that measures the condition or event.

- **Specific**: they should measure only this condition.

- **Reliable**: they should produce the same results when measuring the same condition.

- **Sensitive**: they should reflect changes in the condition.

- **Operate**: they should be measurable using tested standards.
• **Affordable**: they should not cost too much.
• **Timely**: they should measure at relevant and appropriate intervals.
• **Feasible**: they should be possible to carry out.

*Note: Every indicator must have a source.*

**Expressing an indicator**

**Numerical indicators:**

• A **number** is commonly used for output, such as the number of women who received antiretroviral prophylaxis in a set time.

• A **ratio** compares two or more cohorts, such as comparing HIV incidence in 12–15-year-olds with 16–21-year-olds.

• **Percentage** compares two numbers and is usually used as an outcome indicator, such as the percentage of people who returned for post-test counselling out of the total number tested.

• **Average** divides the total by a smaller measure, such as the average daily count of all patients on antiretrovirals at a site in one month.

• **Rate** is the number of new indicators compared in a total, such as new infections compared with the total population over one year; the prevalence rate.

**Qualitative indicators:**

• friendly attitude towards clients
• implementing protocols in the right sequence
• user-friendly physical environment

**Monitoring can be applied within the facility with to**

• improve service
• monitor post-rape care
• monitor post-rape care effect

**Monitoring tools are**

• card systems
• data review
• ongoing interviews
• audits for standards
• reports
• checklists
Monitoring requirements are
- baseline data
- performance indicators and results

8.4 : Monitoring post-rape care facility

<table>
<thead>
<tr>
<th>Method</th>
<th>The group offers short suggestions for the post-rape care services to be monitored, procedures used and who will conduct it.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key point</td>
<td>Monitoring service delivery is very critical because it ensures maintaining good quality service.</td>
</tr>
</tbody>
</table>

Content

Kenya is committed to the ‘three ones’ principle which originated from the International Conference on AIDS and STIs in Africa (ICASA) that was held in September 2003 in Nairobi, and was agreed upon in April 2004 between countries ravaged by HIV and AIDS and development partners, as a basis for concerted country-level action to scale up national responses to HIV and AIDS.

The three ones are
- one agreed AIDS Action Framework that provides the basis for coordinating the work of all partners
- one national AIDS coordinating authority with a broad-based multi-sectoral mandate
- one agreed country-level monitoring and evaluation system

National and international indicators
The following are examples of indicator targets to which the post-rape care programs contribute:
National AIDS Control Council (NACC) indicators

- number of health care providers trained on post-exposure prophylaxis (#47)
- number of health facilities with post-exposure prophylaxis (#48)
- percentage of police officers aware of post-exposure prophylaxis for sexual violence survivors (#49)
- percentage of antiretroviral sites with post-exposure prophylaxis and post-rape care (#50)
- percentage of health workers trained on post-exposure prophylaxis with post-rape care (#51)
- number of provincial hospitals with comprehensive care (#68)
- number of district hospitals with comprehensive care (#69)
- percentage of district hospitals with links to at least four health centres for continuum of care services (#70)
- percentage of health facilities providing comprehensive care linked to community care networks (#76)

Millennium Development Goals indicator

- reduced HIV prevalence among pregnant women aged 5–24 years (Goal 6, Target 7, no. 18)

Data quality

Definitions:

- Data are the raw facts collected and form the basis for what we know.
- Information is the result of transforming the data by adding order, context and purpose.
- Knowledge comes from adding meaning to information by making connections and comparisons and exploring causes and consequences.

Data quality management

Any data collected and reported must be of the best possible quality because decisions, related to the effectiveness and efficiency of any project, are based on the data collected during monitoring and evaluation. To ensure data quality and to avoid unnecessary and costly data repair, a data quality plan should support the monitoring and evaluation plan. The data quality plan helps ensure valid, reliable, timely and precise data for planning monitoring and evaluation and the activities that follow. The data quality plan is the record of how the project managed its data quality and is an excellent source for the auditor during a data quality audit.

Factors that influence data quality

- Technical determinants
  - standard indicators
o data collection forms
o appropriate information technology
o data presentation
o trained people

- System and environment determinants
  o resources
  o roles and responsibilities
  o organizational culture

- Behavioural determinants (those collecting data)
  o motivation
  o attitudes and values
  o confidence
  o sense of responsibility

Note: Good data quality is monitoring and evaluation information that is useful and used.

Table 5. Elements of data quality: summary

<table>
<thead>
<tr>
<th>Data quality element</th>
<th>Definition</th>
<th>Questions to ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>- A tool measures what one wants to measure</td>
<td>- Is there a relationship between the activity program and what is measured?</td>
</tr>
<tr>
<td></td>
<td>- The intended was measured.</td>
<td>- Is the data transcribed? Is there potential for error?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Are steps to limit transcription error (double keying data for large surveys, built in validation checks, random checks)?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- What to do with data errors?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Is the correct formula applied consistently to the raw data from all sites all the time?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- What to do with missing or incomplete data?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Are the final numbers accurate and the total add up?</td>
</tr>
<tr>
<td>Data quality element</td>
<td>Definition</td>
<td>Questions to ask</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Reliable</td>
<td>- Consistent measurement</td>
<td>- Is the same instrument used every year in each site?</td>
</tr>
<tr>
<td></td>
<td>- The intended was consistently measured</td>
<td>- Are data collected the same every year in each site?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Do the procedures ensure the data are free from significant error and bias from instructions, indicator information sheets, and training?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timely</td>
<td>- Data aid decisions after being collected, collated and reported</td>
<td>- Are data available frequently enough to inform management decisions?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Are data collected regularly to meet management needs?</td>
</tr>
<tr>
<td></td>
<td>- Data are relevant</td>
<td>- Are there data from the intervention start?</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precise</td>
<td>- Accurate, (measure of bias)</td>
<td>- Are the data reported as soon as possible after collection?</td>
</tr>
<tr>
<td></td>
<td>- Precise (measure of error)</td>
<td>- Is the margin of error less than the expected change measured?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Are the margins of error acceptable for program decisions?</td>
</tr>
<tr>
<td></td>
<td>- The margin of error is less than the effect</td>
<td>- Have issues around precision been reported?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Would an increase in the degree of accuracy be more costly than the increased value?</td>
</tr>
</tbody>
</table>

Refer to annex 9: data quality appraisal tool

**8.5 End workshop**

Before the workshop ends, participants should do a post-test and evaluate the course. Each participant should be given a certificate of participation.

60 / Clinical Care for Survivors of Sexual Violence
## ANNEXES

### 1. Schedule

<table>
<thead>
<tr>
<th>TIME</th>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td></td>
</tr>
<tr>
<td>8.00–8.30 am</td>
<td>Introduction, set climate</td>
</tr>
<tr>
<td>8.30–10.30 am</td>
<td>Sexual violence and the law</td>
</tr>
<tr>
<td>10.30–11.00 am</td>
<td><strong>Tea break</strong></td>
</tr>
<tr>
<td>11.00 am –1.00 pm</td>
<td>Comprehensive clinical care</td>
</tr>
<tr>
<td>1.00–2.00</td>
<td><strong>Lunch break</strong></td>
</tr>
<tr>
<td>2.00–4.30 pm</td>
<td>Counselling</td>
</tr>
<tr>
<td>Day 2</td>
<td></td>
</tr>
<tr>
<td>8.00–10.30 am</td>
<td>Forensic examination and specimen collection</td>
</tr>
<tr>
<td>10.30–11.00 am</td>
<td><strong>Tea break</strong></td>
</tr>
<tr>
<td>11.00 am –1.00 pm</td>
<td>Presentation on forensic examination and documentation</td>
</tr>
<tr>
<td>1.00–2.00 pm</td>
<td><strong>Lunch break</strong></td>
</tr>
<tr>
<td>2.00–4.30 pm</td>
<td>Referral mechanisms</td>
</tr>
<tr>
<td>Day 3</td>
<td></td>
</tr>
<tr>
<td>8.00–10.30 am</td>
<td>Registration and information management</td>
</tr>
<tr>
<td>10.30–11.00 am</td>
<td><strong>Tea break</strong></td>
</tr>
<tr>
<td>11.00 am –1.00 pm</td>
<td>Supervision for quality improvement</td>
</tr>
<tr>
<td>1.00–2.00 pm</td>
<td><strong>Lunch break</strong></td>
</tr>
<tr>
<td>2.00–4.30 pm</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td></td>
<td>Way forward</td>
</tr>
</tbody>
</table>
2. Management of sexual violence training pre-course and post-course evaluation

1. What comprises sexual violence?

_________________________________________________________________

_________________________________________________________________

2. What are key procedures to be undertaken when a survivor presents:
   o within 72 hours
     ___________________________________________________________
     ___________________________________________________________
   o after 72 hours
     ___________________________________________________________
     ___________________________________________________________

3. What type of drugs are used as post-exposure prophylaxis (PEP) and emergency contraception (EC)?

_________________________________________________________________

_________________________________________________________________

4. Who is to conduct the examination of a survivor?

_________________________________________________________________

5. What specimens are to be collected?

_________________________________________________________________

_________________________________________________________________

6. Where and how are these specimens to be stored?

_________________________________________________________________

_________________________________________________________________

7. Do survivors need to be counselled?

_________________________________________________________________

_________________________________________________________________
8. Who should offer the counselling?

____________________________________________________________________

____________________________________________________________________

9. What tools are used in documenting cases of sexual violence and what is their importance?

____________________________________________________________________

____________________________________________________________________

10. What options would you give to a female survivor concerning the possibility of pregnancy?

____________________________________________________________________

____________________________________________________________________
3. Case studies

Catherine, 13 years, was playing with her friend near her house. The deputy head teacher, also her neighbour, called her to his house. Catherine refused to go because she feared the teacher. Instead, she and her friend ran away. As soon as Catherine reached home, she told her uncle what had happened. Her uncle, who was a former schoolmate of the teacher and drank with him on Friday nights, did not take her seriously and did nothing.

At school Catherine found that the deputy head teacher was suddenly everywhere, trying to block her way from the toilets, caning her for rules she did not break and forcing her to run errands for him. One day he demanded that she stay after school, claiming she had disobeyed him during recess. Although Catherine was afraid of the teacher, she stayed after school because she did not know who else to turn to. She was afraid of what the teacher would if she disobeyed him. Once alone the deputy head teacher forced Catherine to have sex with him, threatening to get her thrown out of school if she resisted.

‘I was 30 years old and married when I was gang raped. I had temporarily separated from my husband, amid fleeing and insecurity, when government soldiers attacked the village. I, together with a friend and my young sister, ran into the bush where I met my first ordeal. Six soldiers found me hiding and raped me one after another, starting with the one who seemed to be their commander. This lasted for about three hours. The last one closed my legs, barking at me in Kiswahili, “We mushenzi lala hapo”, meaning “you fool lie there”. I could not even talk. My relatives discovered me later soaked in blood, urine, faeces and men’s semen.

‘I was torn everywhere and developed backache. Before I had recovered, I was again gang raped at a military checkpoint (roadblock). This time 15 soldiers raped me. This left me shattered. I was once again torn to an extent that I could not control my biological functions. The cervix was dislocated and the uterus started hanging out; whenever I am bathing I have to push it back in.

‘My vaginal part and anus are separated by just a thread of flesh, such that when I diarrhoea, I defecate from both front and behind. I was oozing water and blood. The oozing of water and blood has continued up to today, despite the medical treatment I obtained. The fluid is white and sometimes mixed with pus. The one with pus is smelly. When the fluid comes, I have to use a small pad.’

‘My boyfriend, Charles, and I were in the midst of a blossoming romance. We were both university students and our lives seemed full of promise. Early in our relationship Charles introduced me to his roommate, John, an old friend of his. John was always very kind and attentive to me. I grew to feel comfortable in front of him and began to regard him as a brother. One day, I was to meet Charles at his room so we could go to his cousin’s birthday party together. When I arrived at the room, only John was there,
explaining that Charles had to rush to the hospital to be with a sick relative. John urged me to wait for Charles, explaining that he should soon return. Once I sat down, John locked the door and began to fondle me. I tried to tell him to stop but he harshly asked, “Who told you to come here?” My shock turned to terror when he threw me onto the bed and brutally raped me. I screamed, but no rescue came. When he had finished, John smirked and told me that even if I told Charles, my boyfriend would never believe my story. And that is exactly what happened. Charles found it easier to believe that I had enticed his friend, rather than that his friend had raped me.’

Several times a day Edith’s husband forced her to have sex with him, without regard whether Edith was interested in the act. He called her to have sex with her when she was digging, cooking, sweeping, bathing and trying to sleep at night. He was attempting to control Edith, to let her know she was his property and she should not think she had any worth other than what he told her she had. She went to seek advice from her priest. The priest told her to pray and forgive her husband and accept this as her cross to bear.
4. Sexual violence effects

- Fatal outcome
  - Homicide
  - Suicide
  - Maternal death
  - AIDS related

- Non-fatal outcome

- Physical problems
  - Injury
  - Functional impairment
  - Physical symptoms
  - Poor subjective health
  - Permanent disability
  - Severe obesity

- Chronic conditions
  - Chronic pain syndrome
  - Irritable bowel syndrome
  - Gastrointestinal disorder
  - Fibromyalgia
  - Headache

- Negative health behaviour
  - Smoking
  - Alcohol abuse
  - Drug abuse
  - Sexual risk taking
  - Physical inactivity
  - Overeating

- Reproductive problems
  - Unwanted pregnancy
  - Reproductive tract infection and HIV
  - Gynecological disorders
  - Unsafe abortion
  - Pregnancy complications
  - Miscarriages and low birth weight
  - Pelvic inflammatory disease
  - Vaginal irritation and bleeding
  - Rectal pain and bleeding

- Mental problems
  - Post-traumatic stress
  - Depression
  - Anxiety
  - Phobia and panic disorder
  - Eating disorder
  - Sexual dysfunction
  - Low self-esteem
  - Substance abuse
  - Disturbed sleeping pattern
  - Psychic numbness
### Moh 363

**Ministry of Health National Rape Management Guidelines:**

Examination documentation form for survivors of rape/sexual assault (to be used as clinical notes to guide filling in of the P3 form)

<table>
<thead>
<tr>
<th>MOH 363</th>
<th>PRC1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>MM DD Year</td>
</tr>
<tr>
<td>Province Code</td>
<td>District Code</td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Contacts</td>
<td></td>
</tr>
<tr>
<td>DATE AND TIME OF EXAMINATION</td>
<td>DATE AND TIME OF ASSAULT</td>
</tr>
<tr>
<td>MM DD Year</td>
<td>HR Min AM PM</td>
</tr>
<tr>
<td>Alleged Assaults</td>
<td>No. of Assaults</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>Known (Indicate relation to victim)</td>
<td></td>
</tr>
<tr>
<td>Place Assault Occurred</td>
<td></td>
</tr>
<tr>
<td>Chief Complaints / Presenting Symptoms</td>
<td></td>
</tr>
<tr>
<td>Circumstances surrounding the incident (patient account) remember to record (penetration, how / where, what was used/struggle)</td>
<td></td>
</tr>
<tr>
<td>Type of Assault</td>
<td></td>
</tr>
<tr>
<td>Oral</td>
<td>Use of Condom?</td>
</tr>
<tr>
<td>Vaginal</td>
<td>Yes</td>
</tr>
<tr>
<td>Anal</td>
<td>Yes (Indicate which station &amp; when)</td>
</tr>
<tr>
<td>Other sex</td>
<td></td>
</tr>
<tr>
<td>Attended a health facility before this one?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes (Indicate which one &amp; where)</td>
<td></td>
</tr>
<tr>
<td>Were you treated?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Were you given any notes?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Comments

Significant medical history / surgical

**OB / GYN HISTORY**

- Parity
- Contraception type
- LMP
- Known Pregnancy?
- Date of last consensual sexual intercourse

**GENERAL CONDITION**

- BP
- Temp
- HR
- Pulse Rate
- Demeanour (calm, looks age or not, etc.)

**PSYCHOLOGICAL ASSESSMENT**

- Mental state (normal, confused, flashback, hyper-aroused, dazed, comatose, retarding, extremely calm)

**Did the patient change clothes?**

- Yes | No
- Were the clothes put on non-plastic paper bags? Yes | No
- Were the clothes given to the police? Yes | No
- Did the police sign rape register at health facility? Yes | No

**Did the patient have a bath?**

- Yes | No
- Did the patient go to the toilet?
- Long Call
- Short Call
- Does the survivor have any details on the assailant? (Is the assailant known, is there any relation, did the assailant leave any marks on the assailant etc.? Yes | No

*Comments*
MOH 363

Clinical Care for Survivors of Sexual Violence

•Sexual violence revised.indd   68
3/14/07   9:35:58 AM
MOH 363

Physical examination (indicate sites and nature of injuries, bruises and marks outside of the genitalia)

Please use the sketches below to indicate injuries, inflammations, marks on various body parts

Sketch of person

Anterior view

Posterior view

Female Genitalia

Male Genitalia
6. PRC 2

---

**Clinical Care for Survivors of Sexual Violence**

---

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7. Real case scenarios

Rose is an 18-year-old girl who has lived on the streets of Nairobi almost half her life. She was among the street children taken into the youth service. She now comes for counselling after being gang raped.

A father brings his 5-year-old daughter. She was raped by two 12-year-old boys. The father was not around the day of the rape. The mother had gone to the market and had left the 5-year-old girl in the kitchen cooking porridge for the 3-year-old sister, when the two boys came and took the smaller girl outside. They came back, locked the kitchen door and raped the girl in turns while closing her mouth.

A neighbour passed by the house of Sidi, an 11-year-old girl, and enquired if her mother was at home. Sidi answered, ‘No’. Then he asked if her aunt was there and she told him her aunt was not there either. Then the man told her he had some sugar for her aunt in his house and Sidi could go and get it for her. When they reached the man’s house, he asked her to follow him inside, which she did because she thought the sugar was inside.

Inside the house the man stripped her panty and defiled her without uttering a word. She screamed for help. Her aunt was nearby, heard her, came running and found the man still on top of Sidi.

A woman was coming from a women’s group meeting at around 6.30 pm. She crossed a river and met a neighbour, who asked her whether she would feel all right if they walked home together; she refused. After a short silence, the man grabbed her so tight she was not able to scream. He dragged her to a nearby bush and raped her, until he no longer had the energy to continue. It was so late the man again offered to escort her home. Since it was so hard to refuse, she accepted.
8. Registration checklist

Policy, standards and guidelines
- Copy of the national rural health policy available
- *National Guidelines on Medical Management of Rape and Sexual Violence* available at
  - Casualty or outpatient department
  - Rape trauma counselling site
  - Laboratory
  - Mother and child health or family planning clinic
  - HIV and post-exposure prophylaxis care clinic
- Flow charts on emergency and regular rape and sexual violence management available at
  - Casualty or outpatient department
  - HIV and post-exposure prophylaxis clinic
- Guidelines on infection prevention available

Human resources
- 2 trained rape trauma and voluntary testing counsellors
- 2 medical personnel trained in forensic and clinical care for sexual violence
- 1 medical personnel trained in antiretroviral and post-exposure prophylaxis management
- Trained personnel on comprehensive post-rape care appointed to provide supervision

Infrastructure
- Adequate signs and directions for comprehensive post-rape care at the entrances
- Well lit, spacious, ventilated and private examination room with examination couch, table, three chairs, sink with running water and dust bin
- Functional central surgical sterilizing unit
- Well lit, spacious, ventilated and private counselling room with chairs and table
- Waiting area with chairs and space
- Secure and lockable cupboard for storing client information
- Cupboard for keeping start dose, commodities and equipment, including emergency contraceptives, antiretrovirals, post-exposure prophylaxis and STI drugs
- Secure and lockable cupboard for specimens and exhibits
Safety
- Sink with running water for hand washing at
  - Casualty
  - Counselling room
- Safety box for sharps in counselling room
- Dust bin for contaminated waste gloves and cotton wool in
  - Casualty
  - Counselling room
- Pit or incinerator

Commodities, supplies and equipment
Adequate supply of
- Speculums in different sizes
- Suture packs
- Gloves
- Emergency contraceptives
- Antiretrovirals dedicated for post-exposure prophylaxis
- STI drugs for prophylaxis
- Local anaesthesia
- Antiseptics
- Detergents
- Analgesics

Records and information system
- Client register
- Client files
- PRC 1 form available at casualty
- PRC 2 form available at HIV and post-exposure prophylaxis clinic
- Post-exposure prophylaxis and emergency contraceptive register

For those facilities without a laboratory facilities
- Manage injuries.
- Take detailed history, do physical examination and record all the information on the PRC 1 form and client register.
- Have at least one nurse trained in post-rape care and offer the services.
- Provide emergency contraceptives and post-exposure prophylaxis.
All health facilities with a functioning laboratory

- Manage injuries.
- Take detailed history and examination and record all the information.
- Give first emergency contraceptive dose with or without follow-up.
- Do initial counselling and testing where services are available.
- Maintain post-rape care register, post-rape laboratory register and fill in PRC 1.
- Refer clients to comprehensive post-rape care facility.
- Have a trained post-rape care nurse or clinical officer and a trained counsellor.

All health facilities with HIV, antiretroviral or comprehensive care where antiretrovirals can be monitored must

- Manage injuries.
- Do a detailed history, examination and documentation.
- Provide emergency and long term post-exposure prophylaxis.
- Provide emergency contraceptives.
- Provide STI prophylaxis or management.
- Provide psychological trauma counselling, HIV testing and post-exposure prophylaxis adherence.
- Fill in PRC 1 and PRC 2 forms and maintain the post-rape care and laboratory registers.
- Manage and support survivors.
- Have a medical or clinical officer trained to manage antiretrovirals and post-exposure prophylaxis.
- Have one trained psychological trauma counsellor.
9. Data quality appraisal

Appraisal can guide regular data quality assessment and help the supervisor.

**Data quality appraisal**

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<thead>
<tr>
<th>Quality being appraised</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
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<tr>
<td>Is there a solid logical relation between the activity and what is measured?</td>
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<td>Are the people collecting data qualified and properly supervised?</td>
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<td>Were known data collection problems appropriately assessed?</td>
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<td>Are steps being taken to limit errors of omission and commission?</td>
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<td>Are steps being taken to correct known data errors?</td>
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<td>Is consistent data collection used?</td>
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<td>Are there procedures for periodic review of data collection, maintenance and processing?</td>
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<td>Are data collection, cleaning, analysis, reporting and quality assessment procedures written?</td>
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<td>Are data quality problems clearly described in final reports?</td>
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<td>Is there a regular schedule of data collection to meet program management needs?</td>
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<td>Are data handed in in a timely manner to allow adequate data cleaning and synthesis?</td>
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<td>Are there safeguards to prevent unauthorized changes in the data?</td>
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<td>Is there a planned independent review of the results?</td>
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Based on the five standards, what is the conclusion regarding the data quality?

Significance of limitations (if any):

Actions needed to address limitations
Bibliography


