COURSE OBJECTIVES

At the completion of this course, participants shall:

1. Explain gender based sexual violence
2. Explain the key provisions in the Sexual Offences Act and other relevant laws
3. Describe the standard medical management for survivors and alleged perpetrators of sexual violence
4. Discuss the process of collecting, handling and preserving forensic evidence following sexual violence
5. Demonstrate ability to provide psychosocial care to a survivor and alleged perpetrator of sexual violence
6. Apply quality management, monitoring and evaluation and referral skills in providing comprehensive post rape care services
7. Discuss sexual violence in a humanitarian crisis context
# Course schedule (Conventional Training)

## Clinical Management of Sexual Violence

<table>
<thead>
<tr>
<th>Time</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.00 – 10.30 am</td>
<td>Preliminaries</td>
<td>Recap of the previous day</td>
<td>Recap of the previous day</td>
<td>Unit 6 Psychological debriefing for trauma survivors and care givers</td>
<td>Unit 6 Referral for SV</td>
</tr>
<tr>
<td></td>
<td>Welcome &amp; Introduction</td>
<td>Module 2 Sexual Violence and the Law</td>
<td>Module 4 Forensic Management</td>
<td>Unit 7 Counsellng ethics</td>
<td>Unit 8 Monitoring and evaluation for SV services (documentation and reporting)</td>
</tr>
<tr>
<td></td>
<td>Course expectations</td>
<td>Unit 1 Background of the Sexual Offences</td>
<td>Unit 1 Definition of terms</td>
<td>Unit 8 The role of community in psychosocial care and support</td>
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<tr>
<td></td>
<td>Course goals &amp; objectives</td>
<td>Act and definition of terms Unit 2 Sexual offences and their punishment</td>
<td>Unit 2 Types of evidence</td>
<td>Unit 8 Counselling support supervision</td>
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<tr>
<td></td>
<td>Course schedule</td>
<td>Unit 3 Role of health care professionals in evidence presentation in court</td>
<td>Unit 3 Forensic examination process</td>
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<tr>
<td></td>
<td>Group norms</td>
<td>Unit 4 Chain of custody of evidence</td>
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<td>Pre-course assessment</td>
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<tr>
<td>10.30 – 11.00 am</td>
<td><strong>TEA BREAK</strong></td>
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<td><strong>TEA BREAK</strong></td>
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<tr>
<td>11.00 – 1.00 pm</td>
<td><strong>Module 1 – Introduction to Gender Based Violence</strong></td>
<td><strong>Module 3 Medical Management</strong></td>
<td><strong>Practical session on forensic management</strong></td>
<td><strong>Practical session on counselling skills</strong></td>
<td><strong>Module 7 Sexual Violence in Humanitarian Crisis Situations</strong></td>
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<tr>
<td></td>
<td>Unit 1 Definition of terms</td>
<td>Unit 1 Informed consent</td>
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<td>Unit 1 Gender vulnerabilities in conflict situations</td>
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<tr>
<td></td>
<td>Unit 2 Situation of GBV</td>
<td>Unit 2 History taking including mental assessment</td>
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<td>Unit 2 Multi-causal nature of sexual violence in humanitarian crisis</td>
</tr>
<tr>
<td></td>
<td>Unit 3 Types of gender based violence</td>
<td>Unit 3 Physical examination</td>
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<td>Unit 3 Minimum set of interventions in crisis situations</td>
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<td>Unit 4 Laboratory investigations</td>
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<td>Unit 4 Multi-sectoral response in managing humanitarian crisis</td>
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<tr>
<td>1.00 – 2.00 pm</td>
<td><strong>LUNCH</strong></td>
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<td><strong>LUNCH</strong></td>
<td><strong>LUNCH</strong></td>
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<tr>
<td>2.00 – 4.30 pm</td>
<td>Unit 4 Causes and Contributing factors of GBV</td>
<td>Unit 5 Management of physical injuries</td>
<td>Unit 5 Psychosocial care Support</td>
<td>Unit 6 Monitoring quality and performance in SV programs</td>
<td>Mid Course Questionnaire</td>
</tr>
<tr>
<td></td>
<td>Effects of GBV</td>
<td>Unit 6 Prevention of HIV transmission, other infections and pregnancy</td>
<td>Unit 1 Introduction to psychosocial care and support</td>
<td>Unit 1 Definition of terms in quality improvement</td>
<td>Course Evaluation</td>
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<tr>
<td></td>
<td>Unit 5 Self exploration/Self awareness on gender issues</td>
<td>Practical session on physical examination of patients using humanistic models and documentation - filling of PRC form and other related documentation</td>
<td>Unit 2 Definition of terms and basic counselling and communication skills</td>
<td>Unit 2 Dimensions of quality</td>
<td>Course Evaluation</td>
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<tr>
<td></td>
<td></td>
<td>Unit 3 Types of counselling</td>
<td>Unit 3 Core principles of quality management</td>
<td>Unit 3 Minimum set of interventions in crisis situations</td>
<td>Course Evaluation</td>
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<td></td>
<td>Unit 4 Counselling children</td>
<td>Unit 4 Methods of monitoring quality</td>
<td></td>
<td>Mid Course Questionnaire</td>
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<tr>
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<td></td>
<td>Unit 5 Trauma</td>
<td>Unit 5 Minimum standards for providing comprehensive PRC in health facilities – Overview of SOPs</td>
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MODULE 1:

INTRODUCTION TO SEXUAL GENDER BASED VIOLENCE
By the end of this module, participants will be able to define key sexual gender based violence terms and sexual gender related concepts.
Specific Objectives

1. Define gender and related terms
2. Discuss gender and sex roles
3. Outline national, regional and global situation of SGBV
4. Outline different types of SGBV
5. Discuss causes, effects and contributing factors to SGBV
6. Conduct self exploration and awareness on gender issues
UNIT 1: Definition of terms
Discussion

- What is Gender?
- What is sex?
- What makes a male be distinct as a male?
- What makes a female be distinct as a female?
Gender

- Gender refers to the socially constructed roles and responsibilities assigned to men and women by society.

- It is a social idea of who a woman and man is.

- Gender roles are learned, vary across cultures and change over time.
Sex

- Sex refers to the biological attributes of men and women.
- Sex is the biological classification (of females and males) defining physical difference among them.
- These attributes are universal and cannot be changed.
## Gender vs. Sex

<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>
<tr>
<td>Man/ woman</td>
<td>Male/ female</td>
</tr>
</tbody>
</table>
Discussion

- What are gender roles? Give examples.

- What are sex roles? Give examples.
Gender roles

They are defined as social expectations of what men & women should do in a given community. The interpretation of these roles is based on culture.
Which one is acceptable?
# Gender vs. Sex roles

<table>
<thead>
<tr>
<th><strong>GENDER</strong></th>
<th><strong>SEX</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Widely shared ideas and expectations (norms) concerning men and women</td>
<td>Physiological attributes that identify a person as male or female e.g.</td>
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<tr>
<td></td>
<td>- genital organs</td>
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<td>- predominant hormones,</td>
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<td></td>
<td>- ability to produce sperm or ova</td>
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<td></td>
<td>- ability to give birth and breastfeeding</td>
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<tr>
<td>Includes ideas about “typically” feminine and masculine characteristics,</td>
<td></td>
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<tr>
<td>abilities, and behavior</td>
<td></td>
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</tbody>
</table>
Gender roles are changing...

**TRADITIONAL**

**Women**
- Caregivers
- Feeding children
- Household chores
- Gathering wild fruits
- Building Houses

**Men**
- Hunting
- Security
- Building houses
- Reconciliation
- Decision making
- Men initiate sex

**CURRENT**
(In some settings)
- Both men and women make decisions
- Both men and women are bread winners
- House hold chores are shared in some families
- Women can initiate and negotiate for sex*
- Better pay/positions
- Women acquiring property
What has influenced the change

- Education
- Advocacy - push by women groups and movements for girl child education, protection of widows, elimination of female genital mutilation, gender based violence
- Global Village – adaptation of western culture
- Legislation: Kenyan constitution, bill of rights
- Economic realities – women forced to seek employment
Other gender related terms

**Gender equity**
Refers to fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and strengths and that these differences should be identified and addressed to rectify the imbalance between the sexes.

**Gender equality**
Is the absence of discrimination - on the basis of a person's sex - in providing opportunities, in allocating resources and benefits or in access to services.
Other Gender related terms

**Gender Sensitivity**: When a person or program is conscious of gender roles, and recognizes that they are socially constructed and can be changed.

**Gender responsiveness**: When a person or program practises gender sensitivity. Actions address gender unfairness/imbalances and discrimination and promote equity, empowerment and advancement for both women and men.
Gender Sensitivity: When a person or program is conscious of gender roles, and recognizes that they are socially constructed and can be changed.

Gender responsiveness: When a person or program practices gender sensitivity. Actions address gender unfairness and discrimination and promote equity, empowerment and advancement for both women and men.
Other gender related terms

**Gender Analysis** -
- investigating and identifying specific needs and responsibilities of girls and boys, women and men with a view to identify gaps, raise concerns and address them.

**Gender mainstreaming** -
- Integrating a gender equality into development
- Ensuring that gender is taken into account in all policies, processes and practices
- It is an approach to achieving gender equality.

Gender Based Violence

Gender-based violence (GBV)
Any harm perpetrated against a person’s will and that has a negative impact on their physical or psychological health, development, and identity of the affected person

SGBV refer to definition pop council, WHO, UNHCR
UNIT 2:
Situation of SGBV
Global statistics on Gender Inequality

- Women are the majority of the world’s poor: 70% of people living in poverty (less than $1/day) are women
- Women are less likely than men to hold paid and regular jobs within the formal employment sector
- Women represent more than two-thirds of the world’s illiterate
- Women are almost entirely excluded from political power: they hold 15.6% of elected parliamentary seats globally
- Women own only 1% of the world’s land
Global Statistics on GBV

- 50% worldwide sexual assaults are against girls 15 years or younger; 2003 (UNFPA) report.
- 100-140 million girls & women are living with consequences of FGM. (J.W Myrum, J. Ward, M. Marsh, 2008)
- Women & girls who have undergone FGC/FGM are more likely to have adverse obstetric outcomes (Sonneveldt, et al., 2007)
- 15-71% women report IPV; 4-12% women report physical abuse during pregnancy; WHO multi country study
- Up to 1 in 5, and 1 in 10 men report experiencing SV as children; (UNFPA, 2003)
- Women who experience domestic violence by their partners have a 50 percent increased risk of contracting HIV (WHO, 2008)
A 2003 survey of South African youth from communities with greater risk of exposure to SV were more likely to be HIV positive or to have had an adolescent pregnancy; (Keesbury J. et al., 2008)

3,000 women in Central Kivu in the DRC were raped between 1999 and mid-2001...rape is used as a method of warfare in the Congo’s ongoing conflict (Human Rights Watch, 2002)

300 Burundian women had been raped; 40 percent had heard about or had witnessed the rape of a minor (UNFPA, 2005)

30% of young survivors (8-19) of the 1994 Rwandan Genocide reported having witnessed rape or sexual mutilation (Neugebauer, R: et al., 2009)
Statistics of GBV in Kenya

KDHS data 2008/9

- 45% of Kenyan women (15-49) have experienced either physical or sexual violence
- One in five Kenyan women (21%) has experienced SV
- Divorced, separated, or widowed women are more likely to be exposed to violence (60%) than their married (42%) and never-married (25%) counterparts.
- 37% of women who have experienced sexual violence report current husbands or partners as the perpetrators
- 57% women in Nyanza have experienced physical violence, followed by those in Western (45%). Women in Nairobi are the least likely to report physical violence (29%).
Statistics of SGBV in Kenya

- A joint report by TSC and Centre for Rights Education and Awareness (CREAW) indicated that 12,660 girls were sexually abused by male teachers between 2003 and 2007 (Kenya Education Rights Update, 2009, 2011).

- A 2008 SGBV assessment of parts of North & South Rift, Coast, Nairobi and Central Kenya found that IDP camps lacked PEP or EC on site, and staff had not been trained on responding to survivors of GBV or the medical management of rape. (Speizer, I. S., A. Pettifor, et al., 2009, Annual police report 2011)
UNIT 3:
Types of SGBV
Forms of Sexual and Gender based violence

- **Physical Violence**: Any forceful or violent physical behavior that causes actual harm. e.g. punching, plucking out hair, biting, choking, kicking, slapping, burning, shoving...

- **Psychological/Emotional Violence**: Any threat to do bodily harm to a partner, a child, a family member, friends or oneself. It involves humiliation, exploitation, intimidation, psychological degradation, verbal aggression and deprivation of freedom and rights. Not only hurt and anger, but also fear and degradation.

- **Harmful Traditional practices**: include FGM, widow inheritance, infanticide, sex discrimination...
Socio-economic Violence: Limit money to conduct duties or needs, not allowing women to work, unequal employment payments for equal work done, salary of woman belonging to the husband...

Sexual Violence: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work
GBV
SGBV-A violation of human rights

- 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 of children
- Right to inherent dignity of the person
UNIT 4: Causes, effects and contributing factors to SGBV
Causes of SGBV

- There are many factors contributing to SGBV. In general, the overriding causes are:
  - *Gender inequity*
  - *Abuse of power*
  - *Lack of respect for human rights*

- In situations of armed conflict and displacement, when community supports and social structures have broken down, women and children face additional risks and are most vulnerable to SGBV
Contributing factors to SGBV

- **Culture** - perceived gender superiority and entitlement
- **Poverty** - inadequate resources increase maltreatment
- **Alcohol and drug abuse** - increases violence
- **Media** - portrayal of women’s bodies as sexual objects
- **Illiteracy** - Increases risk of violence
- **Conflict** - breakdown of law and order
- **Disability** - Increases risk of violence
- **Religion** - doctrine e.g. Submission, prohibited FP
## Effects of SGBV

<table>
<thead>
<tr>
<th>Non Fatal Physical Outcomes</th>
<th>Fatal Outcomes</th>
<th>Mental health outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Injuries, headaches</td>
<td>- Suicide</td>
<td>- Depression</td>
</tr>
<tr>
<td>- Unwanted pregnancy</td>
<td>- Homicide</td>
<td>- Fear</td>
</tr>
<tr>
<td>- STIs</td>
<td>- Maternal mortality</td>
<td>- Anxiety</td>
</tr>
<tr>
<td>- Miscarriage</td>
<td>- HIV/AIDS</td>
<td>- Low self-esteem</td>
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<tr>
<td>- PID, Chronic pelvic pain</td>
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<td>- Sexual dysfunction</td>
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<tr>
<td>- Permanent disabilities</td>
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<td>- Eating problems</td>
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<tr>
<td>- Asthma</td>
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<td>- Obsessive-compulsive disorder</td>
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<tr>
<td>- IBS</td>
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<tr>
<td>- Self-injurious behaviour (smoking, unprotected sex)</td>
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</tbody>
</table>
UNIT 5:
Self Exploration/ self awareness on Gender Issues
Exercise: True or false

- Women are raped by strangers in dark places outside the home.
- Rape of men is more shameful than that of women.
- There is no rape in marriage.
- Women say ‘No’ when they mean ‘Yes’.
- Men rape because they are overcome by sexual urges.
- Men who rape are obviously not normal.
# Myths and facts about rape

<table>
<thead>
<tr>
<th>MYTHS</th>
<th>FACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women ask to be raped.</td>
<td>Rape is violent and 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.</td>
</tr>
<tr>
<td>Sexual violence is impulsive, done for sexual gratification.</td>
<td>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.</td>
</tr>
</tbody>
</table>
## Myths and facts about rape

<table>
<thead>
<tr>
<th>MYTHS</th>
<th>FACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Young attractive girls’ get raped.</td>
<td>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.</td>
</tr>
<tr>
<td>Rapists are strangers.</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.
Thank You
OBJECTIVE

By the end of this module, participants should be able to explain the key provisions in the Sexual Offences Act (SOA) and other relevant laws, and define their roles in the presentation of evidence in court.
UNIT 1: Background to the SOA
• The **SOA** is a law that makes provision for sexual offences, their definition, prevention, and the protection from harm and unlawful sexual acts.

• It was passed by the National Assembly on 31st May 2006, assented to by the president on July 14, 2006, and commenced operation on 21st July 2006.

• In march 2007 the Attorney General set up a task force (TFSOA) to oversee the implementation of the Act.
BACKGROUND OF THE SOA

- Existing laws did not adequately define and deal with cases of sexual violence.
- The penal code had no provisions for protection of victims.
- Sexual offences were classified as offences against morality under the Penal Code, which affected how seriously the crimes were taken and there was no uniform sentencing policy.
- Certain forms of abuse such as sexual harassment, child sex tourism and trafficking in children were not acknowledged.
- The laws presumed that men and boys could not be sexually violated.
- Its purpose of the SOA was to provide comprehensive legislation addressing sexual violence in Kenya.
AIMS OF THE SOA

• It brings together all different sexual offences into one law
• It amends all other laws regarding sexual offences laws e.g. penal code, Evidence Act, Criminal Procedure Law…
• It explains the different sexual offences and different punishments for these offences
• It looks at cases of both male and female victims and so it IS NOT a law by ‘women to fix men”
• For once in laws of Kenya, it provides for minimum sentences, making it a MUST for the court to give those found guilty the sentence stated.
• It ensures that cases of sexual violence can only be withdrawn by the Director of Public Prosecution (DPP) once reported.
AIMS OF THE SOA

- It recognizes persons living with disability (PWD) as persons who need special protection
- People in positions of authority or trust can also be charged with committing sexual crimes
- It looks at new cases of sexual offences against children e.g. child pornography
- It looks at cases where companies can also be charged for committing sexual offences e.g. trafficking women, child pornography
• **Child** – any person under the age of eighteen years (Children's Act)

• **Complainant** - Republic or the alleged victim and in the case of a child or a person with mental disabilities, includes a person who lodges a complaint on behalf of the alleged victim where the victim is unable or inhibited from lodging and following up a complaint of sexual abuse

• **Genital organs** - include the whole or part of male or female genital organs and include the anus.
• **Penetration** - the partial or complete insertion of the genital organs of a person into another person’s genital organs.

• **Indecent act** - any unlawful intentional act which causes-

  (a) any contact between any part of the body of a person with the genital organs, breasts or buttocks of another, but does not include an act that causes penetration.

  (b) exposure or display of any pornographic material to any person against his or her will
• **Consent** – A person consents if he or she agrees by choice and has the freedom and capacity to make that choice.

• **Intermediary** – person given authority by the court to give evidence on behalf of a vulnerable witness and may include a parent, relative, psychologist, counselor, guardian, children's officer or social worker.

• **Sexual offences** – any offence prescribed in the SO Act
UNIT 2: Sexual Offences and their punishment
Rape - a person commits rape if he or she intentionally and unlawfully commits an act which causes penetration with his or her genital organs and the other person does not consent to the penetration or the consent is obtained by force or by means of threats or intimidation of any kind.

Punishment – Ten years but can be enhanced to imprisonment for life.
SEXUAL OFFENCES AND THEIR PUNISHMENT

An act is intentional and unlawful if it is committed –

(a) using coercion - force, threat of harm, abuse of power or authority

(b) under false pretenses or by fraud - confusing persons, some other act being performed,

(c) to a person who is incapable of appreciating the nature of an act - asleep, unconscious, altered state of consciousness, influence of drugs, etc, mentally impaired or a child.
Sexual assault - Any person who unlawfully –

(a) 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;

(b) manipulates any part of his or her body or the body of another person so as to cause penetration of the genital organ into or by any part of the other person's body.

Punishment – Ten years but can be enhanced to imprisonment for life.
Attempted rape - attempt to commit the offence of rape.

Punishment – five years but can be enhanced to life
Defilement - Act which causes penetration with a child.

If child aged eleven years - life imprisonment.

If child is aged between twelve and fifteen – minimum of twenty years
If child is aged between the age of sixteen and eighteen minimum of fifteen years.
Attempted defilement – attempted act of defilement. Punishment - imprisonment for minimum of ten years.

Gang rape - rape or defilement in association with another or others, or any person who, with common intention, is in the company of another or others who commit the offence of rape or defilement. Punishment – 15 years to life.
SEXUAL OFFENCES AND THEIR PUNISHMENT

Indecent act with child – any unlawful intentional act with a child. Any contact between any part of the body of a person with the genital organs, buttocks of another, but does not include an act that causes penetration

Punishment – minimum of ten years.

Compelled or induced indecent acts - Intentionally and unlawfully compelling, inducing or causing another person to engage in an indecent act with –

(a) the person compelling or inducing
SEXUAL OFFENCES AND THEIR PUNISHMENT

(b) a third person;

(c) that other person himself or herself; or

(d) an object, including any part of the body of an animal, in circumstances where that other person -
Compelled or induced indecent acts (cont)

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

(ii) is incapable in law of appreciating the nature of an indecent act

Punishment – minimum of five years.
Sexual harassment - Any person, who being 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.

Punishment – Minimum of 3 years or to a fine of not less than 100,000/= or both
Administering a substance with intent -

**Intentionally** administering a substance to, or **causes a substance to be administered to or taken by**, another person with the **intention** of stupefying or overpowering that person, so as to enable any person to engage in a sexual activity with that person.
SEXUAL OFFENCES AND THEIR PUNISHMENT

Deliberate transmission of HIV or other STI’s minimum sentence of fifteen years to life, whether or not he or she is married to that other person.

Cultural and religious sexual offences - Any person who for cultural or religious reasons forces another person to engage in a sexual act or any act that amounts to an offence under this Act is guilty of an offence.

Punishment - minimum of ten years
Positions of authority or trust - police, jailers, hospital staff, teachers and positions of trust
Any person being a manager or staff of any hospital takes advantage of his/her position and has sexual intercourse with or commits other sexual offence under the Act with any patient in the hospital, such intercourse not amounting to rape is guilty of abuse of position of authority
Punishment – minimum 10 years

Incest – daughter, granddaughter, sister, mother, niece, aunt, grandmother, adopted sister, half sister, half mother (and the corresponding males)
Punishment – minimum 10 years, if victim is below 18 yrs life sentence below
OTHER SEXUAL OFFENCES

• Non disclosure of conviction for sexual offences – when seeking employment or when offered employment. Punishment-minimum 3 years or fine of not less than 50,000/= or both

• Promoting sexual offences with a child – manufactures or distributes articles to promote sexual offences with child, supply or display articles used for sex to encourage child to perform sexual act

• Punishment- minimum of five years or if it’s a company 500,000 or more.
OTHER SEXUAL OFFENCES

- Child Sex tourism - makes travel arrangements on behalf of another to facilitate commission of sexual offence with child.
  Punishment – 10 yrs or more; company 2 million or more

- Child prostitution – procuring or inducing child for sexual activity.
  Punishment – 10 yrs or more

- Child pornography - shows, hires or conveys obscene objects, books, etc depicting children
  Punishment – 6 yrs or more or a fine of 500,000 or both

- Exploitation of prostitution - inciting someone to be a prostitute, controls activities of prostitute
  Punishment – 5 yrs or more or a fine of 500,000 or both

- Prostitution of persons with mental disabilities
  Punishment – 10 yrs or more
S.31 – Evidence of vulnerable (child survivor or mentally sick) witnesses may be given evidence through an intermediary or under the protective cover of a witness protection box or in camera.

S.34 – No evidence as to the character and previous sexual history of the complainant, other than that relating to the offence which is being tried, shall be adduced.

S.37 – Any person who intentionally interferes with a scene of crime or any evidence relating to commission of a sexual offence.- any act which hinders investigations
S.38 – repealed

S.39 – Court can declare a person a dangerous sexual offender and that he/she be supervised

S.40 – Only the order of the DPP has the power to decide whether the prosecution or investigation of sexual offence should be discontinued.

S.43(5) – “Intentional & Unlawful Act”, this section does not apply to persons who are lawfully married to each other.
UNIT 3:
Role of Health Care professionals in evidence presentation in court
Role of health care professionals in evidence presentation in court

• Be able to give facts the survivor presented – relate to 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—not medical jargon.

• Do not give information beyond what one is asked.

• Treat the legal practitioner (s) with respect.
Role of health care professionals in evidence presentation in court

- Not to be afraid to use the phrase “I don’t know”

- Not to lose objectivity by wanting to please whoever called you

- Can refer to books, notes and written information, when presenting evidence.

- Do not draw conclusions unless they are certain.

- If giving evidence on behalf of another doctor, then restrict yourself to the report made by that doctor.
Role of health care professionals in evidence presentation in court

- When giving opinions on the assault, consider:
  - Use of condoms.
  - Whether there was too much bleeding.
1. Hand out (SOA Medical regulations)
MODULE 3: CLINICAL MANAGEMENT
Broad Objectives

• By the end of this module, participants should be able to describe the standard clinical management for survivors and alleged perpetrators of Sexual Violence as per the National Guidelines on Management of Sexual Violence in Kenya, 2013.
Specific Objectives

• Describe informed consent.
• Describe the process of history taking including mental assessment
• Describe the process of physical examination of survivors of sexual violence
• Describe essential laboratory investigations
• Describe management of physical injuries following SV
• Describe prophylactic management of survivors of SV
• Demonstrate the ability to fill the PRC, (MoH 363) and P3 forms
• To increase service provider recognition and timely response to GBV issues in MARPS populations
UNIT 1:
Informed Consent
Informed consent - Medical
Where a health care provider has disclosed all relevant information in regard to the proposed course of treatment to the patient so that the patient can then arrive at a choice as to whether or not to proceed with the same.

Informed Consent - Legal
Where a person has all the relevant information in regard to a certain course of action prior to agreeing to that action. For this consent to be legally valid, the person has to be an adult of sound mind.
Informed Consent

• In practice, obtaining informed consent means explaining all aspects of the consultation to the survivor. HCPs must obtain an informed consent prior to conducting any medical procedures.

• Survivors must be given sufficient information to help them understand the options open to them, to enable them make informed decisions about their care.

• Informed consent is obtained by having the survivor fill in a consent form or provide a thumb print.
Informed Consent

• Examination without consent could result in the HCP provider being charged with sexual violence or trespass of the survivor’s privacy.

• Results of an examination conducted without consent cannot be used in legal proceedings.

• Consent for children, unconscious and mentally ill survivors can be given by their care giver.

Shared Confidentiality

Particular emphasis must be placed on the matter of release of information to other parties that will be involved in the management of the survivor, including the police.
<table>
<thead>
<tr>
<th>AGE GROUP (YEARS)</th>
<th>CHILD</th>
<th>CAREGIVER</th>
<th>IF NO CAREGIVER OR NOT IN CHILD’S BEST INTEREST</th>
<th>MEANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>-</td>
<td>Informed Consent</td>
<td>Other trusted adult’s or case-worker’s informed consent</td>
<td>Written Consent</td>
</tr>
<tr>
<td>6-11</td>
<td>Informed Assent</td>
<td>Informed Consent</td>
<td>Other trusted adult’s or case worker’s informed consent</td>
<td>Oral Assent, Written Consent</td>
</tr>
<tr>
<td>12-14</td>
<td>Informed Assent</td>
<td>Informed Consent</td>
<td>Other trusted adult’s or child’s informed assent. Sufficient level of maturity (of the child) can take due weight.</td>
<td>Written Assent, Written Consent</td>
</tr>
<tr>
<td>15-18</td>
<td>Informed Consent</td>
<td>Obtain informed consent with child’s permission</td>
<td>Child’s informed consent and sufficient level of maturity takes due weight</td>
<td>Written Consent</td>
</tr>
</tbody>
</table>
Unit 2: History Taking
History Taking

History taking and examination should be undertaken immediately after presentation.

A health care providers should therefore:

• Ensure safety and privacy
• Create a climate of trust
• Allow in person for support (if the survivor so wills)
• Obtain history as completely as possible but with compassion, respect and sensitivity

Remember, the survivor has experienced profound trauma and may be agitated, depressed, shameful, fearful, angry, guilty…
History to be obtained

- Explain that you need to understand details of exactly what happened in order to check for all possible injuries.
- Ask survivor to describe what happened at their own pace. Do not interrupt; ask for clarifications/details later.
- Establish the type of violation that occurred to probe use of
Sexual Violence History

- The date and time of the sexual violence
- The location and description of the type of surface on which the violence occurred
- The name, identity and number of assailants
- The nature of the physical contacts and detailed account of violence inflicted
- Use of weapons and restraints
- Use of any medications/drugs/alcohol/inhaled substances
- Use of condoms and lubricants
Sexual Violence History

• Any subsequent activities by the survivor that may alter evidence e.g. bathing, douching, wiping, the use of tampons and changes of clothing

• Any symptoms that may have developed since the violence e.g. genital bleeding, discharge, itching, sores or pain

• Current sexual partner/s

• last consensual sexual intercourse (for adults)
Gynecological history

• Last menstrual period
• Number of pregnancies
• Use (and type) of current contraception methods

Male-specific history

• Any pain or discomfort experienced in the penis, scrotum or anus
• Any urethral or anal discharge
• Difficulty or pain on passing urine or stool
Establish if the survivor did the following:

- Bathed/Douched
- Changed clothes
- Defaecated /micturited
- Sought medical attention
  - Where
  - Treatment/medication provided
  - Notes given
- Reported to Police
  - Where
  - When
History, and Documentation

• Accurate and thorough documentation
  – Acts as link between the occurrence, survivor, healthcare and criminal justice systems
  – Increases chances of success should case get to court.
Points to consider in history taking

• Ask questions gently. Avoid asking questions that have already been documented by other providers
• Avoid distraction or interruption during history taking
• Be non-judgmental, clear, complete, objective
• Be precise about important statements e.g. threats made
• Always use open-ended questions. Avoid leading questions.
• Include name of assailant using qualifying statements e.g. “The survivor reported that…”
• Avoid “alleged”, may be interpreted to mean survivor exaggerated or lied
• Review any documents or paperwork brought by the survivor
History taking for Children

- Ensure privacy
- Approach the child with extreme sensitivity
- Identify yourself as a helping person
- Try to establish a neutral environment and rapport
- Try to establish the child’s developmental level in order to understand any limitations and appropriate interactions
- Ask the child if s/he knows why s/he has come to see you
- Ask the child to describe what happened or is happening to them in their own words. Play therapy may be used.
- Ask open-ended questions and avoid leading questions.
- Consider interviewing the child separately from the caregiver of the child separately
Specific History for Children

• When did this happen?
• Was this the first time this happened or has it happened before?
• What threats were made? Or incentives were given?
• What part of your body was touched or hurt?
• Do you have any pain in your bottom or genital area?
• Is there any blood in your panties?
• Do you have difficulty or pain with voiding or defecating?
• Have you taken a bath since the sexual violence?
• When was your last menstrual period? (girls)
UNIT 3:
Physical Examination
Preparation for physical examination

• Have a complete PRC kit ready prior to examination. This can be locally assembled at the facility
• Allow the survivor to have a support person during examination of they so wish.
• Explain all the procedures you intend to conduct to the survivor and why they are necessary
• **Obtain informed consent**
• As you conduct the examination, explain each step to the survivor
• Make sure that the survivor understands that s/he can stop the procedure at any stage
• Collect both medical and forensic specimens
Physical examination- Head to Toe

- Ensure to undress the survivor in stages.
- Ensure to document in PRC form as you examine.
- Note the survivor’s general appearance and demeanor.
- Take the vital signs- pulse, BP, RR and temperature
- Inspect the hands and wrists for injuries/ligature marks.
- Inspect the face and the eyes.
- Gently palpate scalp for tenderness, swelling, depression.
- Inspect the ears and behind for shadow bruising, which develops when the ear has been struck onto the scalp.
- Inspect for perforated ear drums
- Examine the neck. The neck area is of great forensic interest; bruising can indicate life-threatening violence.
Physical examination- Head to Toe

• Examine breasts and trunk with as much dignity/privacy.
• Inspect the forearms for defense related injuries e.g. include bruises, abrasions, lacerations and incised wounds.
• Examine the inner arms and armpit or axilla for bruises.
• Recline the survivor for abdominal examination i.e. palpation to exclude internal trauma or detect pregnancy.
• While reclined, examine the legs, starting with the front.
• If possible, to ask the survivor to stand for inspection of the back of the legs. An inspection of the buttocks is also best achieved with the survivor standing.
• Collect biological evidence with moistened swabs (for semen, saliva, blood) or tweezers (hair, fibres, grass, soil).
Genito- anal examination

- Examine the external genitalia and anus, as well as any markings on the thighs and buttocks.
- Inspect the mons pubis; examine the vaginal vestibule paying special attention to the labia majora, labia minora, clitoris, hymen or hymenal remnants, posterior fourchette and perineum.
- Swab the external genitalia before any digital exploration or speculum examination.
- Gently stretch the posterior fourchette area to reveal abrasions that are otherwise difficult to see.
- If any bright blood is present, gently swab in order to establish its origin, i.e. whether it is vulval or vaginal.
Genito- anal examination

- Warm the speculum prior to use by immersing it in warm water.
- Insert the speculum along the longitudinal plane of the vulval tissues once the initial muscle resistance has relaxed.
- Inspect the vaginal walls for signs of injury, including abrasions, lacerations and bruising. Collect any trace evidence, such as foreign bodies and hairs if found.
- Suture any tears if indicated.
- Remove the speculum
Head to toe examination for children

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

• Record the height and weight of the child.
• Examine the mouth/pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum
• Record the child’s sexual development.
  – This is to determine if contraception is necessary.
Genito-Anal Examination for Girls

• Speculum exam is not indicated.
  – Can only be used when the child has internal bleeding due to penetration.
  – Examination should be done under general anaesthesia. For small girls, use a paediatric speculum.
  – The child may need to be referred to a higher level health facility for this procedure

• Examine the anus.
  – Look for bruises, tears or discharge.
  – Check for the anal sphincter muscle tone.
The Genito-Anal Examination for Boys

• Examine the penis for foreskin injury and urethral meatus discharge.
  – In an older child, the foreskin should be gently pulled back to examine the penis.

• Examine the anus.
  – Look for bruises, tears or discharge.
  – Check for the anal sphincter muscle tone.
  – Consider a digital rectal examination only if medically indicated.
Specimen Collection

- Undress while standing on a sheet of paper to collect any debris on clothes, skin, hair
- Soiled or torn clothing should be given to police
- HVS (adults females only)
  - Lubricate speculum with N/S or clean water
  - Presence of spermatozoa
  - Preservation of sperms
  - Fluid from posterior fornix for examination for sperm
- Swabs from rectum/anus, perineum for sperms - DNA.
- Children do EUA
UNIT 4:
Laboratory Investigations
Investigations for clinical management of the survivor

Investigations are conducted for 2 main purposes:

i. To know the general condition of the survivor

ii. For forensic evidence purposes

Specimen collection should be done during the examination. Investigations done on various specimens include:

**Urine**
- Urinalysis - microscopy
- Pregnancy test
- Spermatozoa
Investigations for clinical management of the survivor

Blood

- HIV test
- Haemoglobin (Hb) levels
- Liver Function Tests (where possible)
- VDRL
- Hepatitis B

Anal swab

High Vaginal Swab

Oral Swab

- For forensic evidence of spermatozoa

Samples for DNA analysis
Investigations for clinical management of the survivor

- Specimens to check for spermatozoa should only be collected when a survivor presents to the health facility within 5 days of sexual violence.

- HCPs should preserve collected forensic evidence and store it appropriately. This will be handed over to the police for further investigations and processing.
UNIT 5: Management of Physical Injuries
Management of injuries in SV

- Management of any **life threatening** injuries takes precedence over all other aspects of post-rape care
- Minor cuts and abrasions should not delay the delivery of other more **time dependent** treatments.
Management of injuries in SV
General wound care

• Clean any tears, cuts and abrasions and remove dirt, faeces, and dead or damaged tissue.

• Decide if any wounds need suturing. Suture clean wounds within 24 hours. After this time they will have to heal by second intention or delayed primary suture.

• Do not suture very dirty wounds. If there are major contaminated wounds, consider giving appropriate antibiotics and pain relief.

• If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the survivor has been fully vaccinated.
Genital wound care

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

- Where physical injuries result in breach of the skin and mucous membranes, immunize with 0.5mls of Tetanus Toxoid according to the TT schedule.
- Use table below to decide whether to administer tetanus toxoid (which gives active protection) and anti-tetanus immunoglobulin (which gives passive protection) if available.
- If the vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and different sites of administration.
- Advise survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to 1 year).
## Tetanus schedule

<table>
<thead>
<tr>
<th>History of tetanus immunization (number of doses)</th>
<th>If wounds are clean and &lt;6 hours old or minor wounds</th>
<th>All other wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>TT</td>
<td>TIG</td>
<td>TT</td>
</tr>
<tr>
<td>TIG</td>
<td>TT</td>
<td>TIG</td>
</tr>
</tbody>
</table>

Uncertain or not received any, or <3

- YES
- NO
- YES
- YES

3 or more

- NO unless last dose >10 years ago
- NO
- NO unless last dose >5 years ago
- NO

*Reference table from WHO “Clinical Management of Rape Survivors 2004”*
UNIT 6: Prevention of HIV, other STIs and pregnancy
Prophylactic Management

- HIV Prevention.
- Pregnancy Prevention.
- STI prevention.
Post Exposure Prophylaxis (PEP)

• Post Exposure Prophylaxis (PEP) for HIV is the administration of a combination of anti-retroviral (ARV) drugs for 28 days after the exposure to HIV.

• PEP should be started within 72 hours of sexual violence if a survivor tests HIV negative.

• The national guidelines on management of sexual violence in Kenya recommends the use of Triple therapy for PEP.

• In the event that the survivor tests HIV positive, PEP IS NOT RECOMMENDED; the survivor should be referred for HIV care, treatment and follow up.
Post Exposure Prophylaxis (PEP)

• In the event that the survivor declines to take a HIV test, counseling should be continued and other management provided as per the health care provider’s clinical judgment.

• People presenting later than 72 hours after sexual violence should be offered other aspects of post rape care, except PEP.
Blood Monitoring for PEP

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

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

• If HIV positive at first visit, stop PEP and refer for HIV care.
  – Explain that HIV has not occurred as a result of the rape, but from previous exposure
• If survivor declines HIV Testing on the initial visit (within 72 hrs) further counseling is recommended in three days.
• Stop PEP if still declines
<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>PRESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDF + 3TC+ ATV/r</td>
<td></td>
</tr>
<tr>
<td>Tenofovir 300mg</td>
<td>Once a day for 28 days</td>
</tr>
<tr>
<td>Lamivudine 300mg</td>
<td>Once a day for 28 days</td>
</tr>
<tr>
<td>Atazanavir 300 mg/ ritonavir 300mg</td>
<td>Once a day for 28 days</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Recommended PEP Regimens for Children

• The recommended PEP drugs for children are:

   ABC + 3TC +LPV/r
   OR
   AZT + 3TC +LPV/r

• Both syrups and tablets can be used.

• Children’s doses must be given according to weight and/or surface area (Refer to the national ART guidelines 4th Ed. 2011 or paediatric dosing wheels)
# Side Effects of PEP

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Possible side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tenofovir</td>
<td>Renal toxicity and bone mineral loss.</td>
</tr>
<tr>
<td>Zidovudine</td>
<td>Anaemia, gastrointestinal side-effects, and proximal muscle weakness.</td>
</tr>
<tr>
<td>Abacavir</td>
<td>Skin rash, cough, fever, headache, asthenia, diarrhoea</td>
</tr>
<tr>
<td>Lamivudine</td>
<td>gastrointestinal side-effects, anaemia,</td>
</tr>
<tr>
<td>Lopinavir/ ritonavir</td>
<td>gastrointestinal side-effects</td>
</tr>
</tbody>
</table>
Pregnancy prevention

• EC should be given within 120 hours/ 5 days of sexual violence; ideally as early as possible
• EC should be given to all females with secondary sexual characteristics or who have experienced menarche
• EC should not be given to pregnant females or those on reliable contraceptive methods.
• EC does not harm an early pregnancy
• EC is not a form of abortion
• There are no known medical conditions for which EC use is contraindicated.
# ECP options

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Pill composition (per dose)</th>
<th>Examples of brand names</th>
<th>1st dose – no of pills</th>
<th>2nd dose no of pills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levornogestrel only</td>
<td>LNG 750 μg</td>
<td>Postinor-2 Plan B</td>
<td>2</td>
<td>NA</td>
</tr>
<tr>
<td>Combined Estrogen-progesterone pills</td>
<td>EE 30 μg + LNG 150 μg</td>
<td>Microgynon 30, Nordette</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
STI Prevention

• STI prophylaxis should be offered to all survivors of SV
• The HVS performed at initial presentation is done for forensic reasons and not for screening for STIs or to guide antibiotic administration.
• Survivors with a “normal” HVS result should still be offered STI prophylaxis.
• Survivors of SV should be given antibiotics to treat gonorrhoea, chlamydial infection and syphilis.
• Preventive STI regimens can start on the same day as ECP and PEP), although the doses can be spread out to reduce nausea.
<table>
<thead>
<tr>
<th>Males and non-pregnant adult females</th>
<th>STI DOSAGE</th>
<th>ALTERNATIVE REGIMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cefixime 400 mg stat OR</td>
<td>Norfloxacin 800mg stat</td>
<td></td>
</tr>
<tr>
<td>Ceftriaxone 250 mg IM stat PLUS</td>
<td></td>
<td>Doxycycline 100mg b.d. for 7 days</td>
</tr>
<tr>
<td>Azithromycin 1 g stat OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doxycycline 100 mg B.D for 7 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLUS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tinidazole 2 g stat</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant females</td>
<td>Norfloxacin 800mg stat</td>
<td></td>
</tr>
<tr>
<td>Cefixime 400 mg stat OR</td>
<td></td>
<td>Doxycycline 100mg b.d. for 7 days</td>
</tr>
<tr>
<td>Ceftriaxone 250 mg IM stat PLUS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azithromycin 1 g stat OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLUS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tinidazole 2 g stat</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spectinomycin 2g stat</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Amoxil 3g stat +</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Probenecid 1g stat)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Erythromycin 500mg QID for 7 days</td>
</tr>
</tbody>
</table>
STI Management in Children

Recommended children’s prophylaxis drugs are:
• Cefixime
• Azithromycin

Recommended children’s prophylaxis drugs for Trichomoniasis are:

Tinidazole OR Metronidazole
HBV Prevention

• Hepatitis B vaccination provides protection from future exposures Hepatitis B virus infection
• It is not meant to treat an already existing infection
• Given within 14 days of exposure
• It is much less costly to vaccinate all survivors of rape/sexual violence, rather than to test everyone for Hepatitis B antibodies to see who might benefit.
• Ideally, if Hepatitis B Vaccines is available, it should be considered for survivors of sexual violence
• Safe for pregnant women, and in chronic or previous HBV infection
Medical Management of Perpetrators of Sexual Violence

• Perpetrators have the right to medical treatment to ensure they access prophylaxis for HIV/AIDS and STIs and management of physical injuries (Sexual Offences Act 2006).

• The treatment of perpetrators should be the same as for the survivors including collection of forensic specimens and counseling.
Follow up of survivors

2nd visit - 2 weeks

- Provide PEP refill
- Assess adherence to treatments previously given
- Evaluate for STIs and treat if necessary
- Evaluate mental/emotional status and treat or refer as needed
- Provide adherence and trauma counseling
Follow up of survivors

3rd visit - 4 weeks

- Check for PEP completion
- Repeat PDT and refer for care if necessary
- Do follow up vaccinations
- Evaluate for STIs and treat if necessary
- Evaluate mental and emotional status; treat or refer as needed
- Provide trauma counseling
Follow up of survivors

4th visit- 6 weeks

• Evaluate for STIs and treat if necessary
• Evaluate mental and emotional status; refer or treat as needed.
• Provide trauma counseling

5th visit- 3 months

• Retest for HIV and refer for care if necessary
• Evaluate for STIs and treat if necessary
• Evaluate mental and emotional status; refer or treat as needed.
• Provide trauma counseling
UNIT 7:
Filling of PRC and P3 forms
The Post Rape Care Form (MOH 363)

- Ensures details observed and interventions are not left out
- Assists health care provider & police in filling P3 form
- The PRC form is filled in triplicate:
  - Original copy given police – serves as medical notes in court
  - Duplicate copy given to the survivor
  - Triplicate copy remains in the booklet at the facility

- The PRC form should be filled completely
- Ensure confidentiality in storage of medical records
Summary of findings to be documented in the PRC Form

1. General examination
   • Document the state of clothes- the colour, whether stained or torn, where they were taken to
   • Document vital signs of the survivor

2. Mental assessment
   • Document as per the psychological assessment form
Summary of findings to be documented in the PRC Form

3. Systemic examination

- **Central nervous system** - level of consciousness, affect
- **Musculo-skeletal system** - physical disabilities, posture control and gait, swellings, bruises, lacerations, dislocations, bite marks, scratches on the body of survivor from head to toe.
- **Perineum** - The perineum consists of the clitoris, labia majora and minora, vagina, mons pubis, introitus, fossa navicularis, vestibule, hymen, penis, prepuce, scrotum, urethra, anus, gluteal region, inner medial thighs.
Summary of findings to be documented in the PRC Form

3. Systemic examination ctd...

• In the above areas, document: Any tenderness, bruises, abrasions, cuts, teeth -marks, scratch marks bleeding, discharge, old scars (question their source if any)
• Details of the anus- shape, dilatation (sphincter muscle tone), fissures, faecal matter on perianal skin, bleeding from rectal tears.
• Details of the hymen- shape, position, colour, and type e.g. Cribriform, septal, crescent shaped, carunculae.
• Position and size of tears e.g. At 3 o’clock 1 cm etc.
Thank You!
MODULE 4: FORENSIC MANAGEMENT
Discuss the process of collecting, handling, storage/preservation and transportation of forensic evidence.
Specific Objectives

• Definition of key terms.
• Identify different types of evidence.
• Describe the process of collecting, handling and preserving evidence.
• Identify the different components of a rape kit.
• Define the chain of custody and steps involved.
UNIT 1: Definition of terms
Key Terms

- Forensic examination
- Medical Practitioner.
- Designated Persons.
- Evidence.
- Forensic evidence.
- Physical evidence.
- Crime scene.
Forensic examination

A medical assessment conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion.
Medical practitioner means a practitioner registered in accordance with section 6 of the ‘Medical Practitioners and Dentists Act’.
Designated Persons

- This includes a nurse registered under section 12(1) of the 'Nurses Act'
- ‘Nurses Act’ or clinical officer registered under section 7 of the ‘Clinical Officers (training, registration and licensing) Act’
Forensic Evidence

• This is the evidence collected during a medical examination.

• The role of forensic evidence in criminal investigation includes the following:
  – To link or delink the perpetrator to the crime. (Aside from SV, including deliberate HIV/AIDS infection, which constitutes another crime on its own);
  – To ascertain that SV occurred;
  – To help in collection of data on perpetrators of SV.

• In most cases, forensic evidence is the only thing that can link the perpetrator to the crime.
• Defined as anything submitted before a court of law to ascertain the issues under investigation
Physical Evidence

• This refers to any object, material or substance found in connection with an investigation

• Helps establish:
  – the identity of the offender,
  – the circumstances of the crime or
  – any other fact deemed to be important to the process.
Physical Evidence

• Value of physical Evidence.
  – Can place the suspect in contact with the crime scene.
  – Can exonerate the innocent.
  – Can corroborate victims testimony.
  – Can prove a crime has been committed.
  – More reliable than eye witness testimony
Crime scene?

• An area?

• A person?

• An Object?
Is a scene, either a person, place or an object capable of yielding physical evidence which has the potential of assisting in apprehending or exonerating the suspect
UNIT 2: Types of evidence
There are two types of evidence that need to be collected:

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

- Evidence to link the alleged assailant to the assault e.g. perpetrators torn clothes, used condoms, grass and blood stains, scratches and bite marks on the perpetrator, and eyewitness testimony i.e. people last saw the perpetrator walking away with the survivor (this is because circumstantial evidence can help the court adduce the guilt of the accused).
Locard’s exchange principle:
States that, every contact leaves a trace........

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

- Clothings
  - Survivors
  - Perpetrator
- Condoms
- Buccal swabs
- Blood stains
- Blood
- High vaginal swabs
- Anal swabs
- Polythene paper bags
- Weapons
  - Knives, guns, metal rod etc
UNIT 3:
Forensic Examination Process
Forensic examination process

- Collection of specimen
- Refer to trainer’s manual (page 69)
Specimen Collection

- Undress while standing on a sheet of paper to collect any debris on clothes, skin, hair
- Soiled or torn clothing will be given to police
- HVS (adults females only)
  - Lubricate speculum with N/S or clean water
  - Presence of spermatozoa
  - Preservation of sperms
  - Fluid from posterior fornix for examination for sperm
- Swabs from rectum/anus, perineum for sperms - DNA.
- Children do EUA
Principles to be adhered to during specimen collection for forensic analysis

• **Avoid contamination:** Store each exhibit separately. Wear gloves.

• **Collect early:** Try to collect forensic specimen as soon as possible.

• **Handle appropriately:** Ensure that specimens are packed, stored and transported correctly.

• **Label accurately**

• **Ensure security:** Specimen should be packed to ensure that they are secure and tamper proof.

• **Maintain continuity:** Details of the transfer of the specimen between individuals should also be recorded. An exhibit register should be maintained at each facility.
# Types of forensic evidence

<table>
<thead>
<tr>
<th>specimen</th>
<th>Method of preservation</th>
<th>Test for</th>
<th>Purpose for testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saliva</td>
<td>Place in clean dry bottle, screw top, boil, cool &amp; refrigerated</td>
<td>Secretor group</td>
<td>Identify assailant</td>
</tr>
<tr>
<td>Mouth swabs</td>
<td>Air dry</td>
<td>DNA</td>
<td>Identify assailant/victim</td>
</tr>
<tr>
<td>Urine of both the survivor and suspect</td>
<td>Place in clean dry bottle, screw top, cool &amp; refrigerated</td>
<td>Alcohol &amp; drugs</td>
<td>• Ability of survivor to consent&lt;br&gt;• Whether the assailant/survivor abused drugs</td>
</tr>
<tr>
<td>Pubic/head hair</td>
<td>Pick hairs using non powdered gloves and store in an envelop. lift using tape and store on acetate sheet</td>
<td>Transfer evidence analysis</td>
<td>Identify assailant/survivors</td>
</tr>
<tr>
<td>Foreign fibres/grass/soil</td>
<td>Lift using tape, hand pick and store in a khaki envelop</td>
<td>Transfer evidence analysis</td>
<td>Corroborate evidence</td>
</tr>
<tr>
<td>Types of forensic evidence</td>
<td>Preservation and Handling</td>
<td>Identification</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td></td>
</tr>
<tr>
<td>blood</td>
<td>Clean sterile dry bottle with screw top or transfer liquid blood onto sterile cotton gauze and air dry. For drugs analysis, whole liquid blood should be submitted</td>
<td>DNA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ability of survivor to consent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>semen/seminal stain</td>
<td>Dry semen stained clothing in open air. Do not dry in front of a fire or artificial means or directly under sun. Preserve in khaki paper. N.B. Avoid plastic paper bags</td>
<td>Assailants DNA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify assailant</td>
<td></td>
</tr>
<tr>
<td>Finger nail scrapings/Clippings</td>
<td>Pick the nail scrapings/clippings using non powder gloves and store in paper envelops</td>
<td>DNA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify assailant/victim</td>
<td></td>
</tr>
<tr>
<td>Blood stained clothes</td>
<td>As for semen stains</td>
<td>DNA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify assailant/survivors</td>
<td></td>
</tr>
<tr>
<td>Bite marks</td>
<td>plastacine</td>
<td>Dental impression</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Victims/suspect identification</td>
<td></td>
</tr>
</tbody>
</table>
• All tests and results should be recorded in a laboratory rape register.
• The above tests can be carried out on the survivor and also on the perpetrator.
• With regard to the perpetrator, the court can under section 26(2) and 36 of the SOA, order that certain specific samples be collected.
• **Document collection:** It is good practice to compile an itemized list in the survivor’s medical notes or reports of all specimen collected and details of when, and to whom, they were transferred.
# Rape kit for evidence collection

<table>
<thead>
<tr>
<th>Rape Kit Description Item</th>
<th>Rape Kit Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powder free (latex gloves)</td>
<td>1</td>
</tr>
<tr>
<td>six stick swabs</td>
<td>6</td>
</tr>
<tr>
<td>Masking tape for use as labels</td>
<td>1</td>
</tr>
<tr>
<td>Brown envelopes for collecting specimen Clothes, panty, pubic hair, etc</td>
<td>20</td>
</tr>
<tr>
<td>Tape measures</td>
<td>1</td>
</tr>
<tr>
<td>Needles</td>
<td>3</td>
</tr>
<tr>
<td>Syringes</td>
<td>3</td>
</tr>
<tr>
<td>Vercutainer tube</td>
<td>2</td>
</tr>
<tr>
<td>6 doses of PEP, EC, STI prevention drugs</td>
<td></td>
</tr>
<tr>
<td>Anti emetic</td>
<td></td>
</tr>
</tbody>
</table>
UNIT 4: Chain of Custody
Chain of Custody

• Is the process of obtaining, preserving and conveying evidence through accountable tracking mechanisms from the community, health facility and finally to the police.

• Also refers to a paper trail where the movement of evidence is traceable through the different persons in the chain of sample collection, analysis, investigation and litigation)

• The following documents play a key role
Chain of Custody (Documentation)

**PRC form:**

- The PRC is a medical form filled when attending to the survivor.
- Can be filled by a doctor, a clinical officer or a nurse.
- Filled in triplicate:
  - Original (white) copy – Police
  - Duplicate (yellow) copy – Survivors
  - Triplicate (green) copy – Hospital
- Information obtained from the survivor should be recorded at the first contact of the survivor.
- The forms should be signed by both:
  - Police and HCPs
P3 form:

• This is a Police form.
• It is filled by a health practitioner or the police surgeon as evidence that an assault has occurred.
• The P3 form is for all assaults and therefore not specific to sexual violence.
• The P3 form is filled and returned to the police for custody accompanied with the PRC form.
• Should be filled in free of charge.
• Survivor should get a copy of the form once its filled in and signed.
Thank You!
At the completion of this session, participants shall recognise the psychosocial needs of survivors of sexual violence and refer appropriately for support.
Specific objectives

- Define communication
- Describe the communication process
- Discuss the GATHER model of communication
- Explain the importance of core conditions when handling a survivor of sexual violence
- Discuss the survivor-centred approach to handling clients
- Recognize the psychosocial considerations of different types of survivors of sexual violence
- List types of counseling in management of sexual violence
Unit 1: Introduction to Psychosocial Care
### Types of emotional/psychological effects of SV

<table>
<thead>
<tr>
<th>Psychological/emotional</th>
<th>Shock/denial, Irritability/anger, Depression, Restricted affect (reduced ability to express emotions) Loss of self-esteem, Loss of security/loss of trust in others, Guilt/shame/embarrassment Suicidal ideation (thoughts of suicide and death), Emotional neglect in infants from sick depressed mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Numbing/apathy (detachment, loss of caring Multiple pains, Abdominal pain, Headache, Chest pain, General malaise, Fatigue,</td>
</tr>
</tbody>
</table>
# Types of emotional/psychological effects of SV

<table>
<thead>
<tr>
<th>Cognitive</th>
<th>Difficulty concentrating, Impaired memory, Lack of concentration, Regression of milestones, forgetfulness or poor memory, Confusion, Poor academic performance, Confusion, Forgetfulness, Disorientation, Memory loss, Personality changes, Anxiety, Seizures, Agitation, Aggression, Hallucinations, Delusions, Mood disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural</td>
<td>Social withdrawal, Nightmares/flashbacks Loss of appetite, Diminished interest in activities or sex, Hyper vigilance (always being &quot;on your guard&quot;), Insomnia, Exaggerated startle response (jumpiness), Panic attacks, Eating problems/disorders</td>
</tr>
<tr>
<td></td>
<td><strong>IN CHILDREN</strong>, Hyperactivity, Withdrawal and self neglect, Aggressiveness, Sleep disturbance, Acting out, Stealing, Drug abuse and sexual promiscuity</td>
</tr>
</tbody>
</table>
Psychosocial assessment

Definition

• A formal evaluation of an individual or family intended to clarify their non-biomedical needs and priorities.

• Important for diagnosis and documentation of issues of concern and referral purposes.
Psychosocial assessment

What are we assessing?

- Individual and family
- Household
- Extended family strengths and supports
- Resources
- Support
- Psychological symptoms
- Social status, risks
Psychosocial assessment

When do we perform assessments and by whom?

• First visit recommended
• At each follow-up visit as needed
• By Trained providers can conduct this psychosocial assessment
• Attached is a psychosocial guide for assessment
• Different types of psychosocial interventions
  • Debriefing
  • counselling
  • psychotherapy
  • psychiatric care
Psychotherapy

Types of psychotherapy

- Psychotherapy
- Play therapy
- Family therapy
- Group therapy
- Support Groups e.g. post-test clubs

What is psychotherapy

- This is a process between therapist and a child where the child and his family are assisted to acknowledge, comprehend, understand and adjust through their feelings, thoughts and behavior to handle a problem
What is family therapy?

• This is where the counselor works with the whole family for the benefit of the child taking into consideration the family systems, social and cultural values and the environment.

What is group therapy?

• This is a therapeutic process between a counselor and a group with common problems.

• The group benefits from sharing experiences, learning from others, counselor’s professionalism and personal interaction.
What is a support group?
• This is an informal group made of clients/patients with similar problems
• Not necessarily structured
• Can be open or closed
• It is a common psychosocial intervention offered to willing participants (important to prepare the clients in advance)

What is play therapy?
• This is a therapy directed through play and games using toys and other tools or appropriate media
• Art therapy is directed through drawings and paintings
Psychiatric treatment

- Patients with PTSD, depression, acute anxiety or severe behavioural problems should be referred to the psychiatrist for further evaluation and management. Survivors who develop major psychiatric disorders or emergencies may require admission to hospital and closely observed. They will also require medications such as antidepressants and anxiolytics. These clients require close monitoring in case they develop suicidal tendency. After recovery and discharge from the wards, they need to continue taking medication and to attend the psychiatrist clinic until such a time they are fully recovered.
The role of the social worker is to work with the team to manage the patient.

Assessing the Whole Person

Medical Knowledge for Social Workers: A Team Approach important
Orphans, widows, exploitation

Fostering and adoption services

Shelter and linkage to legal services

Advocacy services

Medical assessment

Educational services and Child placement

Financial services, Housing and Legal services

Vocational services and Other case management

Networking and referral of clients
When to refer

• You may need to refer a patient to a mental health professional under the following circumstances:
  • Psychological symptoms (depression, anxiety, psychosis, aggression) are severe, chronic & significantly disrupt the child’s daily functioning
  • Person expresses suicidal ideation. Person expresses thoughts of wanting to harm others
  • Person presents with a significant substance abuse problem
  • Has a history of being sexually, physically or emotionally abused
  • If referral is made, it is **very important** that you and the psychiatrist/mental health professional remain in **close collaborative contact** through the treatment process
Unit 2: Definition of terms and basic counseling and communication
Counseling

Counselling is a **Relationship** (safe, client-centred, dynamic) within which a range of **Skills and Techniques** are used in order to facilitate a **Process** of helping positive change from:

- Dissatisfaction to satisfaction
- Pain to comfort
- Low esteem to high esteem
- Low social skill to high social skills
Counseling aims to help people to:

- Understand their situation more clearly
- Identify a range of options for improving the situation
- Make choices which fit their values, feelings and needs
- Make their own decisions and act on them
- Cope better with an issue
- Develop life skills such as being able to talk about sex with a partner
- Provide support for others whilst preserving their own strength
• **Communication** is exchanging information. It is the process by which people attempt to share meanings of symbolic transmissions.

• Communication is a two way process.

• It is the act of transmitting information, thoughts, opinions and feelings through speech, signs and actions from a source to a receiver.
Communication process

- A health worker needs to communicate effectively with the survivor of sexual violence.
- The communication process consists of a message, source, channel, receiver, effect and feedback.
- Communication begins with a message that is developed at the source.
- The source channels the message to the receiver. This message has an effect which produces feedback.
The communication process

- Source
- Message
- Channel
- Receiver
- Feedback
• Remember, communication is not about words, so much is communicated non verbally.

• The health care provider should be able to pick both verbal and non-verbal messages from the client
Communication

 Facial Expression 55%
 Tone of Voice 38%
 Words 7%

Source: Budlong et al, 1993
• GATHER is an acronym that describes guides the HCW in gathering information from the survivor or perpetrator in a sensitive and supportive way. The acronym stands for:
G - Greet

• **Greet** the client or patient

• Introduce yourself

• Identify the agency *(Where appropriate)*

• Explain the process: “I am going to ask you a series of questions that will help me to assist you.”

• Explain the principle of confidentiality *(and when confidentiality might be broken)*

• Check whether the client/patient has any questions
A – Ask

• Explain to client why you are about to ask questions: “I will ask you some questions and use the information you give me to help in the management of what has happened to you.

• Work more with open ended questions
  – Please tell me what happened
  – Sexual violence: How would you describe the person (s) who sexually violated you?
  – What do you remember about the person (s) who sexually violated you?
T – Tell

- Validate the client and give him/her support; (believe them)
  Tell them something like:
  - I’m sorry this happened to you
  - No one deserves to be abused
  - I’m glad that you were able to tell me. I think we can help you. Now I would like to ask you a few more questions that will give me more information so that together we can figure out how best to help you.
H – Help

- At this stage, gather as much information as you can about the GBV so that you can most effectively help the client.
  - Who is the perpetrator?
  - How long has the abuse been happening?
  - Are you in danger now?

- If there is any indication that the client is in danger or may be in danger in the future, develop a safety plan

- Begin to identify what kinds of referrals client may need/want, identifying options rather than giving advice
E – Educate

• Begin the education phase by reviewing what you’ve heard: “you’ve said”, we’ve discussed”; “you mentioned”

• Normalize the clients feelings: “It is not uncommon for people to experience…”; “Many people have similar feelings…”

• Strategize about how client can manage their here and now feelings. Ask what the client has done in the past that has been helpful in managing such reactions. Identify and support strengths.
Refer, Return, Review

- Be prepared with a list of organization to which you may refer the client (social services, police, shelter).

- If possible, call organizations or other referral points while client is sitting with you to schedule appointments.

- Schedule a time for the client to return for follow-up.

- Review plans for self-care, referrals, and follow-up to make sure client understands.
Unit 3:
Types of counseling in management of sexual violence
Types of counseling in management of sexual violence

- Trauma counseling and psycho-education
- EC counseling and unwanted pregnancies
- Pre-and post-test HIV counseling
- Adherence counseling for Post exposure prophylaxis (PEP) for HIV and other STIs
- Follow-up sessions
- Psychosocial support for groups and the community
- Counselling of the person(s) accompanying the survivor
- Information on survivors’ rights, including legal care.
Unit 4: Counseling children
Counseling children

- Children require action oriented approaches to facilitate the counselling process.
- Because some children may have no experience of an adult listening to them and
- Therefore may react with suspicion or resistance to the counsellor.
Communicating about sensitive issues

• Children may be hesitant to discuss their problems for a variety of reasons, such as:
  
  • Children may feel embarrassed or ashamed talking about issues related to sex, HIV and AIDS and death because these are taboo subjects.
  
  • Children may be too young to put their feelings or experiences into words.
  
  • Some cultures forbid children to question or disagree with adults.
  
  • Children fear hurting those they love.

As a starting point, meet the children on their level. This involves using creative and non-threatening methods to explore sensitive issues and to help them express their feelings.
The language of children

To communicate to children you must be able to speak and understand their language. Children speak 3 languages:

- The language of the body
- The language of play
- Spoken language
The language of children

Four indirect methods that can help children express their feelings:

- Drawing
- Story telling
- Drama
- Play
Knowledge needed to communicate with children

• Knowing how to assess the child’s understanding
• Knowing what the likely reactions and questions are and how to handle them
• Knowing what difficult questions children may ask and how to handle them
• Knowing how to handle your feelings and reactions during the process of counselling
Tone of voice

When dealing with children it is important to pay attention to your tone of voice.

- The tone indicates your thoughts and attitudes.
- If you speak too quietly or hesitantly the caller may find it hard to have confidence in you as a helper.
- It would be counterproductive to be forceful.
- Try to talk clearly at a fairly steady level rather than mumble or stumble.
- Avoid sounding rushed or excited.
- Try to mirror the tone of the child to help them hear the emotion conveyed.
Do’s for communicating with children

• Do take a “one down position,” which means showing the child that he/she knows more about certain things than an adult?

• Use minimal encouragers. This means using brief words and gestures to encourage the child to go on talking.

• Be as fully present as possible. “The whole of you should be there.”

• Externalizing. This involves separating the problem from the child e.g. not labelling a child a truant, bed wetter or orphan.

• Call children by their names not by colour, height, size or place of origin and most importantly not by labelling them in relation to bad behaviour.
Do’s for communicating with children

• Reframe (or re-label). Reframing involves restating the situation the child has described in a more positive way. For example, if a child says that a playmate has told him that his mother has AIDS because she is a sinner, the counsellor can explain that AIDS affects all kinds of people and that AIDS is not a sin.

• Be patient. There is no need to rush; children will tell or show you what they are ready to show or tell you. Even if they are quiet, there are thoughts going through their head. Try to move at their pace.

• Show interest in the child. Children will feel valued if you show interest in their lives.
Do’s for communicating with children

• Be open and honest with facts. If you give information be accurate and precise.

• Maintain a non-judgmental attitude. Counsellors are not trained to be judges of children but to offer badly needed emotional support.

• Be empathetic. Put yourself in the shoes of the children and feel with them.

• Maintain confidentiality and privacy. Don’t share sensitive information except when necessary to help the child. Handle it within your community.

• Maintain a calm and approachable attitude.

• Maintain a caring attitude.
Do’s for communicating with children

• Show acceptance of the child and what he/she is telling you.

• Factor in differing perceptions, especially, if the child and counsellor have different backgrounds, knowledge and experience.

• Use the local language which the children and their families can understand.

• Understand and maintain control of your own emotions. Refer the child to someone else if you feel your emotional involvement is endangering your ability to help him/her.

• Network with other counsellors for personal support and guidance.
Do’s for communicating with children

• Take children seriously
• Treat children as equals
• Be nice and model good kind behaviours.
• Say “yes” a lot. In fact, for each “no” find two or three things that are “yes”.
• Word things in positive terms
• Tell them their feelings are okay.
• Set boundaries that keep them safe.
• Delight in their discoveries, share their excitement.
• Discuss their dreams and nightmares.
• Laugh at their jokes.
• Be relaxed, calm, loving, and nurturing as much as possible.
Don’ts for communicating with children

• Don’t have a judgmental attitude.
• Don’t speak in a commanding manner.
• Don’t compare children.
• Don’t make empty promises.
• Don’t talk too much.
• Don’t interrupt when a child is talking.
• Don’t blame the child as he/she tries to express his/her feelings.
• Don’t look down upon the child.
• Don’t ignore the child.
Don’ts for communicating with children

• Don’t allow emotions like anger, jealousy and fear to develop.
• Don’t form a sexual relationship with the child you are helping.
• Don’t use negative body language such as negative facial expressions or sitting postures.
• Don’t evaluate the situation too quickly.
• Don’t give the child too much information all at once.
• Don’t patronize the interview process
• Don’t sit or stand at higher level than children
• Don’t put words in the child’s mouth or let other adults do so
Don’ts for communicating with children

• Don’t interrupt the child
• Don’t talk too much about yourself (unless asked)
• Don’t continue with the interview if a child gets upset (stop and take break, ask if it’s ok to go on).
Unit 5: Trauma
Definition of trauma

• The word ‘trauma’ comes from a Greek word meaning a ‘wound’ or a ‘piercing’

• Psychological trauma - an emotional or psychological injury, usually resulting from an extremely stressful or life-threatening situation

• Freud – talks about Ego, a protective shield that protects individual from external stimuli that might otherwise overwhelm the ego - Trauma results in infringement of this Ego space
Classification of trauma

- Primary - direct experience
- Secondary
  - Second-hand (vicarious) experiences such as hearing accounts of violence
  - Refers to trauma affecting workers who help trauma and disaster survivors
  - Also known as compassion fatigue, secondary or vicarious traumatization, and "burn out"
  - Professionals affected include mental health professionals, emergency workers, physicians, fire fighters, police, search and rescue, journalists exposed to overdose of survivor suffering
Post-traumatic stress disorder (PTSD) once called ‘shell shock’ or ‘battle fatigue’ syndrome (after World War 1), is a serious condition that can develop after a person has experienced or witnessed a traumatic or terrifying event in which serious physical harm occurred or was threatened.
Causes of PSTD

- PTSD is a lasting consequence of traumatic ordeals that cause intense fear, helplessness, or horror, causes include
  - a sexual or physical assault
  - the unexpected death of a loved one
  - an accident
  - war
  - natural disasters
  - Families of survivors can also develop posttraumatic stress disorder, as can service providers working with traumatized persons.
Symptoms of PTSD

- **Re-living:** People with PTSD repeatedly re-live the ordeal through thoughts and memories of the trauma. These may include flashbacks, hallucinations and nightmares.

- **Avoiding:** The person may avoid people, places, thoughts or situations that may remind him or her of the trauma. This can lead to feelings of detachment and isolation from family and friends.

- **Increased arousal:** These include excessive emotions; problems relating to others, including feeling or showing affection; difficulty falling or staying asleep; irritability; difficulty concentrating; The person may also suffer physical symptoms, such as increased blood pressure and heart rate.
Trauma psychological responses/effects of trauma

- Response patterns are similar across different trauma types i.e. Sexual assault and rape, child sexual and physical abuse, domestic violence, environmental disasters, crime survivors, combat trauma e.g. Vietnam war, Iraq etc., Holocaust and torture
- Variations in response might vary due to vulnerabilities like age, psychological state at exposure etc.
Trauma psychological responses/ effects of trauma

Emotional
• Fear, anxiety and intrusion (nightmares etc)
• Depression
• Self esteem disturbances
• Anger
• Guilt and shame

Cognitive
• Perceptual disturbances

Biological
• Physiological hyper arousal
• Somatic disturbances
Trauma psychological responses/ effects of trauma

<table>
<thead>
<tr>
<th>Behavioural</th>
<th>Interpersonal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aggressive behaviour</td>
<td>• Sexuality problems</td>
</tr>
<tr>
<td>• Suicidal behaviour</td>
<td>• Relationship problems</td>
</tr>
<tr>
<td>• Substance abuse</td>
<td>• Re victimization</td>
</tr>
<tr>
<td>• Impaired social functioning</td>
<td>• Victim becomes victimizer</td>
</tr>
<tr>
<td>• Personality disorders</td>
<td></td>
</tr>
</tbody>
</table>
Unit 6:
Psychological debriefing for trauma survivors and care givers
Debriefing: What is it

• Debriefing also known as critical incident stress debriefing (CISD) is a specific technique designed to assist individuals or groups in dealing with the physical or psychological symptoms that are generally associated with trauma exposure.

• Debriefing allows those involved with the incident to process the event and reflect on its impact. Ideally, debriefing can be conducted on or near the site of the event.
Why is it done

- Evidence from crisis intervention indicates return to normal functioning and reduced likelihood of developing long term problems e.g. PTSD if debriefing is done. It is normally carried out after a shared trauma as a group procedure with not more than 15 participants best timed within 72 hours within the event, with a follow up 3 weeks later to make decisions on further interventions.
Objectives of debriefing

- To facilitate ventilation of impressions and reactions
- Cognitive reorganization, through clear understanding of events and reactions/ Form a clear perspective of the events.
- Decrease in sense of uniqueness or abnormality of reactions achieving normalization through sharing
- Mobilization of resources within and outside the group, increasing group support, solidarity and cohesion
- Preparation for experiences, such as symptoms or reactions which may arise
Objectives of debriefing

• Identification of avenues of further assistance
• Identify current or likely critical incident stress symptoms.
• Access information about normal stress responses to abnormal experiences.
• Mobilize problem-solving strategies.
• Find avenues to address personal needs.
Stages of debriefing and purpose of each stage

Initial stage

- Immediate needs are met (Maslow’s) - practical help or support, comfort, protection from further threat or distress

Middle stage

- Telling the story, making sense of the experience, ventilating feelings as appropriate, linking people to systems of support

Final stage

- Identification of needs for future intervention
Unit 7: Counseling ethics
Fundamental principles of counselling

- **Autonomy**: The right of patients to make decisions on their own behalf (or in the case of patients less than 18 years of age, individuals acting for the child, i.e. parents or guardians). All steps taken in providing services are based on the informed consent of the survivor.

- **Beneficence**: The duty or obligation to act in the best interests of the survivor.

- **Non-maleficence**: The duty or obligation to avoid harm to the survivor.

- **Justice or fairness**: Doing and giving what is rightfully due to the survivor.
Ethical guidelines for counselors

- Counsellors need to be aware of what their own needs are, what they are getting from their work, and how their own behaviour and needs influence their clients.

- Counsellors should have the training and experience necessary for the assessments they make and the interventions they attempt.

- Counsellors need to become aware of the boundaries of their competence and seek qualified supervision or refer clients to other professionals when they recognize that they have reached their limit with a given client.
Ethical guidelines for counselors

- It is important for counsellors to have some theoretical framework, of behaviour change to guide them in their practice.
- Counsellors need to recognize the importance of updating their knowledge and skills through various forms of continuing educations.
- Counsellors should avoid any relationships with clients that could be a threat to therapy.
- It is the counsellor’s responsibility to inform clients of any circumstances that are likely to affect the confidentiality of their relationship and of any other matters that may negatively influence the relationship.
Ethical guidelines for counselors

• It is imperative that counsellors be aware of their own values and attitudes, recognizing the role that their belief system plays in their relationships with their clients, and avoid imposing their beliefs, either subtly or directly.

• It is important that counsellors inform their clients about matters such as the goals of counselling, techniques and procedures that will be employed possible risks associated with entering the relationship, and any other factors that are likely to affect the client’s decision to begin therapy.
Ethical guidelines for counselors

- Counsellors must realize that they teach their clients through setting and example.

- Counsellors need to learn how to think about and deal with ethical dilemmas, realizing that most ethical issues are complex and defy simple solutions. Willingness of a counsellor to seek consultation is a sign of professional maturity.
Unit 8: The role of the community in psychosocial care & support
Types of community based care

**Home Based Care**
- It is the provision of health services by formal and informal care givers in the patient’s home in order to promote, restore and maintain a person’s maximum level of comfort, function and health, including care towards a dignified death (WHO).

**Home Community Based Care**
- It is an integrated, comprehensive, continuum of care for the survivors. Here there is a formal linkage with health facilities with the purpose of referrals for continuum of care.

- **Community Based Treatment Services**
- It encompasses the “services “that we provide at health facility and the community with an emphasis on the latter.
Key players in home community based care and their roles

The Client

• The client is a key player in his own care and his involvement in decisions making to optimize in safety and risk reduction. The client needs to comply and adhere to treatment prescribed and appointments made. The client should be assisted to identify a safe place to stay or protective measures to take to, minimize further risks of sexual violence.

The Family

• The family should be supported to accept and adjust to the situation; need to be given factual information, the challenges they expect and how to deal with them. They should know the locally available services and collaborate with other service providers to ensure the client gets services when needed like legal services, spiritual care etc.
The Community

• The health care worker should help the community understand the impact of having many of their members ill health and unable to contribute to the community development. You should educate the community to accept the situation of the client and collaborate with existing agencies to meet the needs of the client. You need to clarify to the community’s role in public stigma reduction.
Key players in home community based care and their roles

The Health Worker

- The role of the health workers is technical support on the relevant areas of care to the patient, family care giver and the community health worker who are in direct contact with the client on a daily basis. The initial diagnosis is made by the health worker either in a health facility or in a community setup. Initiate linkage referral and networking systems for the client. Clarify and advise on the available support services where the client is enrolled.
Key players in home community based care and their roles

The Government

- In this context the government consists of the different government ministries regulating service provision, professional bodies, and non government organizations. The health care worker as the government representative has a responsibility to create a supporting policy environment for community level activity to optimize client care.

- The Ministry of Health should assist in developing policies and guidelines to give direction for HCBC services. Provide checks and balances for maintenance of quality standard of care.
Self care tips for the survivor

Physical self-care:

- Maintain a balanced diet and drink a lot of clean water
- Try to get enough sleep
- Avoid overusing stimulants like caffeine, sugar, and nicotine.
- Avoid depending on sleeping pills and tranquilizers
- Use stress reduction techniques e.g. exercise (jogging, aerobics, walking) or relaxation (yoga, massage, music, hot baths, prayer and/or meditation).
- Seek medical care, if needed
Self care tips for the survivor

Emotional self-care:

• Spend time with people who are positive and supportive.
• Share your experience with a trusted person with whom you are comfortable with.
• Give yourself "time outs." Such as taking quiet moments to reflect, relax and rejuvenate-especially during times you feel stressed or unsafe.
• Consider writing down your emotions on a piece of paper, this usually gives some relief and makes one feel better. One can destroy the piece of paper after ventilating.
• Create time for hobbies or to do activities that you enjoy.
Self care tips for the survivor

Spiritual Support

• For some survivors, they gain their strength from spiritual intervention. One can contact your local pastor/priest/Imam to provide spiritual support

• Make your self-care a priority, not something that happens (or doesn’t happen!) by accident
How can I support someone who has been sexually violated

- Listening and being available
- Believing and not judging
- Offering a safe environment
- Emotional support by friends and family
How to support the survivor who is your spouse or intimate partner

• Sexual Partners: A Special Relationship.
  The spouse or the intimate partner of a survivor has a special role to play in supporting the survivor. Some of the interventions may include the following:
  
  – Listening, being available, Believing, not judging, Providing safety
  
  – Respecting the survivor's decisions
  
  – Allowing recovery time—as long as is needed
  
  – Respecting in a sensitive manner the survivor's wishes for affection or sexual contact
  
  – Addressing one's own feelings of anger, rage, guilt, sadness, confusion, or blame.
Unit 9:
Counseling support supervision
Counseling supervision

- Counsellor supervision is a forum where counsellors reflect on their work with clients and learn from that reflection through their interaction with an experienced counsellor who takes on the role of supervisor. It is a highly collaborative process. The welfare of the client is at the heart of the relationship.

Importance of counselling supervision

- It facilitates the personal and professional development of the counsellor. Helps relieve burnout
- The educative function supports the development of counsellor competencies.
- A competent counsellor will provide quality services
Counseling supervision

How is Counselling Supervision done?

- It can be done in any of the following ways:
  - Self
  - One to one
  - Co-supervision
  - Group supervision - leader led
  - Peer group
  - Team or Staff (Could be internal or external)
  - Others - Mailing (post or email, telephone etc.)
Counseling supervision

The following methods are used in presenting client work

- Verbal reports
- Written, Session notes
- Audio taping
- Video taping
- Live supervision
- one way mirrors
- bug in the ear
- Sit in supervisor
Unit 10: Facilitation skills
Facilitation skills

- This is the ability to conduct training activities effectively

- A good facilitator picks feelings and emotions expressed through verbal and non-verbal communication examples are:
  - Anger
  - Boredom
  - Happiness
  - Frustration
  - Disgust
  - Impatience
  - Disapproval
Facilitation skills

- A good facilitator should practice:
  - Welcoming facial expression.
  - Good appearance, (professional, Image and dressing).
  - Speak in language understood by trainees
  - Be patient
  - Make and maintain eye contact
  - Ask open ended questions.
  - Appreciate by nodding the head etc.
  - Assure trainees of confidentiality in their matters
Facilitation skills

- Good listening skills:
  - Allows speaker to express themselves.
  - Does not interrupt the speaker
  - Is not distracted by the speaker’s delivery, errors and mannerisms
  - Does not allow outside distractions to interfere with the conversation.
  - Pays attention to the speaker (even if the topic is not interesting).
  - Does not start thinking of answers when the other person is still speaking.
Facilitation skills

- Avoid:
  - Shuffling papers
  - No eye contact
  - Appearance- shabby dressing, (professional. Image), turning body away.
  - Looking at your watch
  - Distracted/Interruptions
  - Fidgeting impatiently/yawning/nail biting Scratching the head
  - Disorganization
  - Harsh tone
  - Using complicated language
Facilitation skills

Additional skills:
- Awareness body language communication
- Self disclosure
- Knowledge on how to help group come up with group norms
- Practicing communication skills
- Creating a comfort zone in the group
- Projection of voice
- Giving instructions for activities
- Keeping time on activities
- Facilitating value exercises
- Facilitation of brainstorming in a large group
Facilitation skills

- Additional skills (cont):
  - The use of brainstorming, flip charts & the “fill-in” method to present content
  - Dividing the large group into small groups
  - Using flip charts
  - Use of overheads, transparencies and power point slides
  - Facilitating group discussions
  - Facilitating buzzing in groups
  - Summarization skills
  - How to evaluate and utilise feedback from group
Thank You!
MODULE 6: SUPPORT STRUCTURES FOR PRC SERVICE PROVISION
BROAD OBJECTIVE

By the end of this session, participants shall recognise support structures for SV service provision
SPECIFIC OBJECTIVE

• Discuss the optimal quality of care and support services for survivors

• Describe the referral systems for comprehensive SV service provision.

• Explain the importance of accurate data management.
UNIT 1: Definition of terms in Quality Management
• ‘Quality’ in health care is meeting the needs and expectations of clients with minimum effort, rework and waste

• **Quality improvement** involves the concerted effort to continuously do things better until they are done right the first time, every time.

• Quality Assurance refers to a systematic and planned approach to monitoring, assessing and improving the quality of services on a continuous basis.
UNIT 2:
Dimensions of quality
Dimensions of Quality

• Experts generally recognize several distinct dimensions of quality that vary in importance depending on the context in which QA efforts take place.

• These dimensions of quality are a useful framework that helps health teams to define and analyze their problems and to measure the extent to which they are meeting program standards.
Dimensions of Quality

- Technical competence
- Access to services
  - Geographic access
  - Economic access
  - Social or cultural access
  - Organizational access
- Effectiveness of services
- Interpersonal relations
- Efficiency
- Continuity
- Safety
- Amenities/physical infrastructure
UNIT 3: Core principles of quality management
Dimensions of Quality

Four Core Principles of Quality Management

- QA focuses on four core principles namely;
- The client
- Systems and processes
- Measurement
- Teamwork
UNIT 4: Methods of Monitoring quality
Methods of monitoring quality

1. Suggestion boxes-A suggestion box is a device for obtaining additional comments, questions, and requests. The box is used for collecting slips of paper with input from consumers of a service.

2. Immediate feedback-Immediate feedback is information about performance that leads to action to affirm or develop performance.

3. Rumours-These are unfounded facts based on hearsay.

4. Self assessment - This takes the form of a questionnaire set for the health care professionals to assess quality of SV services that they provide to client.
5. Client satisfaction tools - For client exit interviews, the interviewer interviews clients as they leave the service site after they have received the requisite services.

6. Counsellor support supervision

7. Checklist - A check list is a tool used as an aid to memory. It helps to ensure consistency and completeness in carrying out a task.

8. Data analysis - Data analysis is a process of gathering, modelling, and transforming data with the goal of highlighting useful information, suggesting conclusions, and supporting decision making.

9. Giving feedback – given to relevant stakeholders, to facilitate communal decision making on QI measures.
UNIT 5:
Minimum standards for providing comprehensive SV services
### Minimum Standards for Providing Comprehensive SV services

<table>
<thead>
<tr>
<th>Health facility without a lab</th>
<th>Minimum Standards</th>
<th>Reporting requirements</th>
<th>Minimum capacity requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage injuries as much as possible</td>
<td>Fill in PRC form in triplicate</td>
<td>A trained nurse</td>
<td></td>
</tr>
<tr>
<td>Detailed history, examination and documentation (refer for HVS, PEP/EC, STI)</td>
<td>Maintain PRC register</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please ensure that the survivor has a copy of the PRC form and takes it to the laboratory</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Minimum Standards for Providing Comprehensive SV in Health Facilities

<table>
<thead>
<tr>
<th>Health facility with functioning lab</th>
<th>Minimum Standards</th>
<th>Reporting requirements</th>
<th>Minimum capacity requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Manage injuries as much as possible</td>
<td>Fill in PRC form in triplicate</td>
<td>A trained nurse and/or a clinical officer</td>
</tr>
<tr>
<td></td>
<td>Detailed history, examination and documentation (including HVS)</td>
<td>Maintain a PRC register</td>
<td>A trained counselor (where counseling is offered)</td>
</tr>
<tr>
<td></td>
<td>Ideally, 1st doses of PEP/EC should be provided (even where follow up management is not possible)</td>
<td>Maintain a laboratory register</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Where HCT services are available, provide initial counseling</td>
<td>Referral to comprehensive post rape care facility</td>
<td></td>
</tr>
<tr>
<td>Health facility with ARV/CC/PRC services</td>
<td>Minimum Standards</td>
<td>Reporting requirements</td>
<td>Minimum capacity requirements</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-------------------</td>
<td>------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Mnx of injuries, Hx taking, examination &amp; documentation PEP, EC, STI HIV pre &amp; post test, Trauma &amp; PEP adherence</td>
<td>PRC form</td>
<td>PRC register</td>
<td>PRC/ART trained MO, Nurse &amp; /or RCO, Trained counselor</td>
</tr>
<tr>
<td></td>
<td>PRC register</td>
<td>Lab register</td>
<td>Lab</td>
</tr>
<tr>
<td></td>
<td>comprehensive PRC care</td>
<td>Follow up</td>
<td>Preservation of specimen</td>
</tr>
</tbody>
</table>
UNIT 6:
Referral Systems For Survivors Of SV Service Provision
Definition: ‘Effective Referral is a process by which a client’s immediate needs are assessed, prioritized and the clients is provided with assistance in assessing the necessary services

Referrals help provide better services.

Referral components:
• Problem identification
• Problem assessment
• Problem diagnosis
• Referral counseling
• Communication.
• Transfer
• Facility feedback
• Community feedback
Definition: ‘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 facility.

• **Horizontal referral**: the client is transferred to a similar facility because there is a temporary lack of certain services or for a second opinion.
REFERRAL STRATEGIES

- Client-held card
- Client-referral form
- Provider assisted referral
- Verbal referral
Types of referrals

• **Consultancy referral**: a client is referred for specialized care.

• **Central referral**: a client is referred to a central point for commonly shared services e.g. support groups

• **Community referral**: the client is referred from the community to the health facility or vice versa.
• Referral helps provide better services.

• When referral is appropriate and properly executed it aids recovery, psychological and emotional support, diagnosis, treatment, and specialized care.

• Referral for legal aid, safety and security
UNIT 7:
Monitoring and Evaluation for SV Services
MONITORING AND EVALUATION

- **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

• Monitoring and Evaluation Types

• *Formative needs assessments* are conducted during planning or re-planning of 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 AND EVALUATION

- 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. Outputs, which are the immediate program results and may be in three forms:
  - number of activities conducted in each area, such as training
  - access or measuring service adequacy
  - services used or measurement of extent services were used
IMPORTANCE OF ACCURATE DATA MANAGEMENT

• Quality Data Management

• This involves the process of accurate recording, timely reporting, and appropriate data entry and storage, prior to its analysis and feedback.

• Quality data management for includes:

• Utilizing appropriate nationally approved recording and reporting tools for collecting, analyzing and reporting data.

• Accurate recording and entry of data

• Confidential and proper storage of client records
• **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.
IMPORTANCE OF ACCURATE DATA 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.
IMPORTANCE OF ACCURATE DATA MANAGEMENT

• The data quality plan helps ensure valid, reliable, timely and precise data for planning, monitoring and evaluation.

• This can also be to inform program implementation and quality improvement.

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

Factors that influence data quality

1. Technical determinants
   - standard indicators
   - data collection forms
   - appropriate information technology
   - data presentation
   - trained people
IMPORTANCE OF ACCURATE DATA MANAGEMENT

2. System and environment determinants
   - resources
   - roles and responsibilities
   - organizational culture

3. Behavioral determinants (those collecting data)
   - motivation
   - attitudes and values
   - Confidence
   - sense of responsibility
### Elements of data quality

<table>
<thead>
<tr>
<th>Data quality element</th>
<th>Definition</th>
</tr>
</thead>
</table>
| Valid                | ▪ A tool measures what one wants to measure  
▪ The intended was measured. |
| Reliable             | ▪ Consistent measurement  
▪ The intended was consistently measured |
### Elements of data quality

<table>
<thead>
<tr>
<th>Data quality element</th>
<th>Definition</th>
</tr>
</thead>
</table>
| **Timely**           | - Data aid decisions after being collected, collated and reported  
                        - Data are relevant |
| **Precise**          | - Accurate (measure of bias)  
                        - Precise (measure of error)  
                        - The margin of error is less than the effect |
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.

• 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 counseling out of the total number tested.
POST RAPE CARE PROGRAM INDICATORS

- **Average** divides the total by a smaller measure, such as the average daily count of all patients on antiretroviral 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
POST RAPE CARE PROGRAM INDICATORS

• 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
IMPORTANCE OF ACCURATE DATA MANAGEMENT

Fill out the data management tools

1. PRC form (MoH 363)
2. PRC register
3. Laboratory register
4. Trauma counselor form
5. Monthly summary sheet
6. P3 form
FACILITY FOLLOW UP AND FEEDBACK MECHANISMS

• Monitoring service delivery is very critical as it ensures maintaining quality service provision

• *Monitoring* is the routine, daily assessment of activities toward program objectives.

• It routinely looks at the service quality and what was achieved.
FACILITY FOLLOW UP AND FEEDBACK MECHANISMS

• 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

• Feedback mechanism should be established to allow for a two way communication
• Development of individual/facility work plans for the implementation of the revised national guidelines on management of sexual violence
Thank You!
MODULE 7: HUMANITARIAN CRISIS AND SEXUAL VIOLENCE AND RESPONSES TO CRISIS SITUATIONS
At the completion of this session, participants shall appreciate the relationship between humanitarian crisis and sexual violence and responses to crisis situation.
SPECIFIC OBJECTIVES

- Discuss gender vulnerabilities in conflict situations
- Recognise the multi-causal nature of sexual violence in Humanitarian Crisis
- Describe the minimum set of interventions in crisis situations
- Recognise the need for collaboration
- Identify specific responsibilities for the Health Sector
UNIT 1: Gender Vulnerabilities in Conflict Situations
GENDER VULNERABILITIES IN CONFLICT SITUATIONS

Age and gender are vulnerabilities that predispose women and girls to exploitation and abuse.

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

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

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

- Continual reproductive roles of women and girls - fetching firewood and/or water in unsecure areas
- Abuse of power by the security and humanitarian workers - demand sexual favours in return for goods and services.
- Harmful cultural practices are exacerbated - e.g. – forceful early marriage of the girls in order to meet the lack of resources in the family.
UNIT 2: Multi-causal Nature Of Sexual Violence In Humanitarian Crisis
MULTI-CAUSAL NATURE OF SEXUAL VIOLENCE IN HUMANITARIAN CRISIS

**Understanding the nature of today’s conflicts**

- They occur within state borders, communities and homes.
- They last for a long time
- They are highly politicized
- They are frequently associated with unconventional war-fare
- National accountability mechanisms are characteristically absent
UNIT 3: Minimum Set Of Interventions In Crisis Situations
Three sets of activities are necessary in combating SV in emergency situations:

• Identify activities to be undertaken in the preparedness phase
• Detailed implementation of minimum prevention and response during the early stages of the emergency
• Identify comprehensive actions to be taken in more stabilized phases and during recovery and rehabilitation
Levels of interventions

• *Structural level (primary protection):*
  Preventive measures to ensure rights are recognized and protected (through international, statutory and traditional laws and policies)
Levels of interventions

• *Systemic level (secondary protection):* systems and strategies to monitor and respond when those rights are breached (statutory and traditional legal/justice systems, health care systems, social welfare systems and community mechanisms)
Levels of interventions

• *Operative level (tertiary protection)*: Direct services to meet the needs of women and girls who have been abused.
NEED FOR COLLABORATION

• Sexual violence is a cross-cutting issue, and no one authority, organization or agency alone possesses the knowledge, skills, resources or mandate to respond to the complex needs of the survivors or to tackle the task of preventing violence, yet all have a responsibility to work together to address this serious human rights and public health problem.
Minimal services needed

- Survivors/victims of sexual violence, families, caretakers and community need assistance to cope with the harmful consequences of this nature of violence
- They need health care, psychological and social support, security, and legal redress
- Prevention activities must be put in place to address causes and contributing factors to sexual violence in the setting
NEED FOR COLLABORATION

Minimal services needed

• Providers of all these services must be knowledgeable, skilled, and compassionate in order to help the survivor and community and to establish effective preventive measures.

• Prevention and response to SV requires coordinated action from actors from many sectors (Multi sectoral).
The health care provider’s responsibility

- To provide appropriate comprehensive care to survivors of sexual violence, families, caretakers and community as is documented in the national guidelines on management of sexual violence.
- To collect forensic evidence that might be needed in a subsequent investigation on either during or post crisis period.
- The forensic investigations should result in successful convictions of perpetrators.
Thank You!