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FOREWORD

Sexual Violence (SV) is a life threatening vice that has a devastating impact on the health, social wellbeing and human rights of the survivor, and in particular women and children. Sexual violence against children is a gross violation of children’s rights with severe immediate and long-term physical, psychological and social consequences. Globally at least 150 million girls and 73 million boys under 18 years have experienced some form of sexual violence. In Kenya and at least 32 percent of females and 18 percent of males reported experiencing sexual violence during their childhood. Notable progress has been made in Kenya in establishing laws and policy frameworks to address sexual violence against children. These include The Sexual Offences Act 2006, the National Policy on Gender and Development, National Reproductive Health Policy and the Children’s Act 2001. However, there is still limited guidance on the necessary service delivery standards and management protocols for the management of child survivors of SV.

This document seeks to enhance the capacity of Health Care Providers and Health Management Teams to respond to and support child survivors of sexual violence. Building on both National and International Sexual and Gender Based Violence Standard Operating Procedures (SOPs), the document provides a standardized, user-friendly guide on how to apply child-centered approaches for the effective management and support of child survivors of sexual violence; and describes clear procedures, roles and responsibilities for all health care providers. They provide concise detail on the sequence of steps to follow to ensure the appropriate clinical response that a child survivor of sexual violence should receive at each point of the continuum of comprehensive care within the health facility.

The SOPs recognize that effectively addressing child sexual violence requires a comprehensive, multi-sectoral approach that is supported by strong referral and linkages to complimentary interventions and involves actors and actions that address child sexual violence prevention, recovery and response. The SOPs can make a strong contribution to each of these efforts by ensuring a comprehensive model of quality care and management that is responsive to the needs of child and adolescent survivors of sexual violence in Kenya.

Dr Wanjiru Mukoma
Executive Director
LVCT Health
# Abbreviations & Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>CCC</td>
<td>Comprehensive Care Clinic</td>
</tr>
<tr>
<td>CHMT</td>
<td>County Health Management Team</td>
</tr>
<tr>
<td>CHRIO</td>
<td>County Health Records and Information Officer</td>
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<tr>
<td>CSV</td>
<td>Child Sexual Violence</td>
</tr>
<tr>
<td>EC</td>
<td>Emergency Contraceptive</td>
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<tr>
<td>ICT</td>
<td>Information Communications Technology</td>
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<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
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<tr>
<td>HCP</td>
<td>Health Care Provider</td>
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<td>HTS</td>
<td>HIV Testing Services</td>
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<td>HBV</td>
<td>Hepatitis B Virus</td>
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<tr>
<td>HPV</td>
<td>Human Papillomavirus</td>
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<tr>
<td>MNCH</td>
<td>Maternal, Neonatal and Child Health</td>
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<tr>
<td>MOH</td>
<td>Ministry Of Health</td>
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<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
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<td>PRC</td>
<td>Post Rape Care</td>
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<tr>
<td>RDT</td>
<td>Rapid Diagnostic Test</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>RMHSU</td>
<td>Reproductive Maternal Health Services Unit</td>
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<tr>
<td>SCHRIO</td>
<td>Sub-County Health Records and Information Officer</td>
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<tr>
<td>SGBV</td>
<td>Sexual and Gender Based Violence</td>
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<tr>
<td>SOPs</td>
<td>Standard Operating Procedures</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities and Threats</td>
</tr>
<tr>
<td>TT</td>
<td>Tetanus Toxoid</td>
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<td>WHO</td>
<td>World Health Organization</td>
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In order to better respond to child sexual violence and support child survivors, it is important to understand basic concepts and definitions about child sexual violence. The following terms and definitions have been informed by national and international sexual and gender based violence (SGBV) SOPs and child protection frameworks, and are not intended as legal definitions.

**Adolescence**
The period in human growth and development that occurs after childhood and before adulthood, from ages 10-19

**Child**
Means any person UNDER the age of eighteen (18) years

**Defilement**
An offence of defilement is when a person: Intentionally and unlawfully commits an act which causes penetration with his or her genital organs with a child

**Health Care Provider**
Service providers at facility level, these may include medical doctors and specialists, registered clinical officers, nurses, social workers, laboratory technologists, pharmacists, pharmaceutical technologists, counsellors.

**Puberty**
The stage in life where a boy or girl begins to undergo biological changes that result in sexual maturity. Onset of puberty marks the transition between childhood and adolescence.

**Sexual Violence (SV)**
This SOP adopts the World Health Organization definition of sexual violence (SV) as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic [a person’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.” This definition is expanded to include the forced sex, sexual coercion and rape of adult and/or adolescent men and women, and child sexual abuse.

**Survivor/victim**
A person who has experienced sexual violence (SV). The terms “victim” and “survivor” can be used interchangeably. “Victim” is a term often used in the legal and medical sectors. “Survivor” is the term generally preferred in the psychological and social support sectors because it implies resiliency.
1. ABOUT THE DOCUMENT

1.1. Purpose of the document

These Standard Operating Procedures (SOPs) have been developed to facilitate joint action by all health actors to effectively respond to child sexual violence. They provide a practical guide for health care providers on the appropriate care of children and adolescents who have experienced sexual violence based on current, evidence-based practices. The SOPs have been informed by lessons learned from establishing SV prevention, response and recovery programs in Kenya; and are aligned to the National Sexual and Gender based violence (SGBV) guidelines, National SGBV SOPS, the national SGBV curriculum and the PEPFAR guidance3,4,5,6.

1.2. Scope of the document

The guide is divided into the following sections:

Chapter 1: About the document
Chapter 2: Background
Chapter 3: Key considerations for establishing services for the management of child sexual violence in Kenya
Chapter 4: Comprehensive clinical services for management of child sexual violence
Chapter 5: Health facility standards for management of child sexual violence
Chapter 6: Standard operating procedures for the management of survivors of child sexual violence

Annexes

1.3 Target Audience

This document is primarily intended for use by service providers in public and private health care facilities, to include medical doctors, clinical officers, nurses, social workers, laboratory technologists, pharmacists, pharmaceutical technologists and counsellors. In addition it is a useful guide for national level officers, county and facility health management teams as they plan for resources and implementation of child sexual health programmes.
2. BACKGROUND
Child sexual violence (CSV) is a critical public health, human rights and a developmental issue that has severe consequences on the immediate and long-term health outcomes and well-being of children. The violence against children national survey 2010, indicated that violence against children is a serious problem in Kenya and at least 32 percent of females and 18 percent of males reported experiencing sexual violence during their childhood. Similarly, health facility data point to a higher number of children than adults in need of sexual violence management services.

In Kenya and at least 32 percent of females and 18 percent of males reported experiencing sexual violence during their childhood – Violence against children national survey (2010)

Child survivors of sexual violence require extensive medical, psychosocial and legal support. As such, it is critical that providers of sexual violence (SV), case management/ survivor support services are not only credible and knowledgeable, but are also well-coordinated to ensure comprehensive services that recognize, respect and protect the rights of the child. Child sexual abuse is globally recognized as having wide ranging health, social and mental ramifications for survivors and their care givers. Health care constitutes an essential component of the necessary interventions to mitigate the far-reaching consequences of child sexual abuse.

Despite high levels of sexual violence (SV) among children and a growing recognition of the need to improve the management of child survivors of SV due to its negative clinical outcomes, many developing countries still lack comprehensive policies, legislation and service delivery infrastructure and standards to adequately respond to and effectively manage child SV. Although Kenya has made notable progress in establishing policy frameworks and training curricula specific to strengthening health systems in the delivery of child sexual violence response services, the availability of a comprehensive model of quality care and management that is responsive to the needs of child and adolescent survivors of sexual violence is still absent in most public health facilities in the country. A study conducted by LVCT Health in three facilities in Kenya to assess the standards required in maintaining the chain of evidence in the context of post rape care services revealed that most health care providers lack the required skill in handling child survivors of sexual violence.

2.1. Effects of Sexual Violence on Children and Adolescents

Sexual violence in particular, has devastating physical, psychological and social effects on the survivor. In the long term, SV has far reaching consequences on the community and the country as a whole. In order to better respond to sexual violence and adequately protect survivors, health
care providers should be able to understand the effects and consequences of sexual violence especially so for children and adolescents.

2.2. Guiding principles and rights for working with survivors of child sexual violence

These are the broad set of norms which are considered best practice; the core principles which must be taken into account by all health care providers. The guiding principles are usually in line with the four international guiding principles of the Convention on the Rights of Children: Non-Discrimination; Best Interest of the Child; Survival and Development; and Participation. The following guiding principles guide the behaviour, intervention, and support provided by health care providers involved in the case management of child sexual violence survivors. Specific guiding principles are provided for each SOP in subsequent sections.

1. Ensure the safety of the victim/survivor and his/her family at all times - Remember that s/he may be frightened, and need assurance that s/he is safe. In all types of cases, ensure that s/he is not placed at risk of further harm by the perpetrator.

2. In all cases concerning a child, the best interest of the child should be the primary consideration - Respect the wishes, rights, and dignity of child survivor when making any decision on the most appropriate course of action to respond to an incident of sexual violence.

3. Informed Consent – All health care providers must receive informed consent from the legal guardian when working with a minor, prior to any response service or sharing of information. Children must be consulted and given all the information needed to make an informed decision using child-friendly techniques that encourage them to express themselves.

4. Respect the confidentiality of the affected child survivor and their families at all times.

5. Do No Harm - If documenting, reporting, monitoring or providing a service to a child survivor of sexual violence will have greater risks than benefits, it must be avoided.

6. Ensure non-discrimination in the provision of services – provide services without discrimination based on age, sex, religion, clan, ethnicity, wealth, language, status, political opinion, culture, etc.

7. Ensure that children are participating in the decision making process of services they can access, make sure that children are involved in all decision making processes regarding referral and access to services.
8. If a decision is taken on behalf of the child, the best interests of the child shall be the overriding guide and the appropriate procedures should be followed. The SOPs outline the special procedures for working with child survivors in subsequent sections.
3. **Key Considerations for Establishing Child Sexual Violence Services in Kenya**

This chapter is intended for use by health management teams at the county and facility level, implementing partners and other technical support personnel, to provide programmatic and operational guidance relevant to the establishment, provision and scale up of responsive, child-centered, sexual violence clinical services.

### 3.1. Child Centered Approach

A child centered approach is when the child is seen and kept in focus throughout the process and account is always taken of the child’s perspective when establishing and providing services for child survivors of sexual violence. A child centered approach:

1. Takes into account critical timeframes in childhood and adolescence and tailors interventions according to the developmental needs of the child.
2. Ensures services offered are appropriate to those developmental needs.
3. Provides children with appropriate opportunities to participate in decisions that affect them.
4. Promotes a collaborative approach to influencing the child’s environment and their interactions in those environments.

### 3.2. Strong leadership and governance

Government leadership and the involvement of civil society, NGOs, private sector service providers and other key stakeholders are critical to achieving a broad understanding of and support for the introduction and scale-up of child sexual violence clinical services. Leadership, cooperation and collaboration is required at the national, county and community levels and from different sectors of the community, including government and civil society in preventing and responding to CSV to improve service delivery, avoid duplication and maximize a shared understanding of the situation. To ensure inclusivity, ownership and sustainability of new programs, implementing partners need to consider the following guidance as they engage all key stakeholders:

- Identify and engage all the partners that are involved in SV work within relevant national and the respective county government ministries and other implementing partners. The involvement of the stakeholders should be done from as early as program inception and continued on a regular basis until termination or transition of the program.
- Actively engage in the national and county level SV Technical working groups to give feedback on program progress and where no SV TWG exists, partners should work closely with the county governments establish one in their respective counties.
• Regularly track progress through county and national monitoring and evaluation systems to ensure accountability and strengthen the national data management systems

• Establish or participate in forums that bring together implementing partners that work in the SV field to discuss common activities in order to avoid duplication of efforts and to enhance synergy

3.3. Advocacy

Advocacy plays a crucial role in the establishment and/or scale-up of CSV programmes or services by building support for key decisions on CSV activities and encouraging broader community participation and ownership. Advocacy is also the vehicle that drives evidence-based resourcing and influences policy reforms, and as such is very closely linked to strong data collection and data management processes and systems. The identification of a strong champion or leader(s) and a clear focal person at county and facility level to lead advocacy efforts is vital in promoting accountable and responsive policies, practices, budgets and services to end child sexual violence and foster institutional as well as social change.

3.4. Setting standards

Standards define the desired performance for a health care system or service and provide the basis for measuring quality. The service standards for CSV define the necessary elements of providing safe care of high quality. The following are standards that should be adhered to for the provision of quality CSV services:

• An effective management system should be established to oversee the provision of child sexual violence services

• Providers should be trained, qualified and competent in the provision of child sexual violence services according to standardized child-centered guidelines and operating procedures

• A minimum package of child sexual violence services should be determined to ensure a standardized approach to care is implemented

• Ensure the facility has the necessary medicines, supplies, equipment and environment for providing safe child sexual violence clinical services of good quality

• A standardized system for reporting and referrals should be integrated into service provision

• A system for monitoring, evaluation and knowledge generation should be established

3.5. Capacity building and training

In order to establish a baseline standard of care, health care workers providing medico-legal services to children who have experienced sexual violence and exploitation should be given
specialized training that addresses the medico-legal aspects of service provision (WHO 2013). The following steps should be considered while capacity building for provision of CSV services:

- Assess the human resource situation and constraints and identify opportunities and actions for effective task-shifting in order to achieve results efficiently
- Clearly define the target of training for all the requisite skills and components of the agreed minimum package of services, and determine the specific needs of targeted trainees
- Establish the competencies required of trainees before they can be certified as competent
- Ensure proper trainee selection by developing training standards and a process for the selection of trainees. Because the sex of the health worker may be a critical issue, where possible ensure that both male and female nurses and physicians are trained
- Establish systems and capacities to ensure the transfer of learning from the training site to the service delivery site (follow-up by trainers, on-site mentoring, etc.)
- Involve local law enforcement in the training as investigating and prosecuting child sexual violence and exploitation is a priority
- Periodically review the human resource situation and needs

3.6. Child Protection, Referral and Response Mechanism:

Access to treatment, care and justice after an incident of CSV is essential in ensuring the survivor’s recovery and reintegration into the community without stigma and discrimination. An effective, well-coordinated and integrated protection and response mechanism ensures that child survivors of SV receive the appropriate support. Health assistance is the priority for cases involving sexual violence and/or possible bodily injuries. In the case of CSV, assistance must be in accordance with the SOPs that guide the clinical management of CSV including the provision of emergency contraception and post exposure prophylaxis for HIV. Health Care providers should inform the child/survivor and legal guardian of available assistance and/or any limitations to services. CSV service providers in the referral network must be knowledgeable about the services provided by internal and external actors to whom they refer a child survivor. Children must be accompanied to all services within the referral pathway. A strong protection and referral network ensures that the care provided is comprehensive, responsive and addresses both short and long term recovery needs of the child.
3.7. Monitoring and evaluation

Monitoring and evaluation (M&E) must be an ongoing element of any child sexual violence service delivery programmes. If properly implemented it provides continuous feedback to the planning, management, improvement and scale up CSV response services. An Information Sharing Protocol must be developed; data and information collected should be centrally collected and distributed. This ensures that designed programmes, interventions and services are responsive to the needs of CSV survivors, emerging trends/gaps are identified and effectively managed, and quality services delivered.

Key elements of a robust M&E framework include:

- Key indicators and measurements to track the progress of the programme; select only indicators that are needed to generate the desired information
- A plan for continuous assessment (and operational research) so as to ensure that quality is maintained and to learn from the process of scaling up in a timely way that will enhance future programme decisions
- Regular analysis of any data collected, ensuring data is compiled in a useful format and fed back to facilities, decision-makers and advocates
4. COMPREHENSIVE SERVICES FOR MANAGEMENT OF CHILD SEXUAL VIOLANCE

4.1. Core components of a comprehensive service for child sexual violence

Multi-sectoral linkages are key in the management of services for child sexual violence as they ensure that the child survivors’ medical, psychosocial and legal needs need to be adequately addressed throughout the continuum of care as illustrated in Figure 1. The individual capacity of each of these sectors to address child sexual violence is enhanced through policies and programs that create avenues for linkages. While the management of child sexual violence requires a comprehensive, multi-sectoral approach, in which services at all levels should be child-centered, a comprehensive clinical service for child sexual violence should meet the range of medical and psychosocial needs of the child survivor from the first point of contact through to the final stages of recovery and reintegration into the community. This document specifically addresses the health sector component of a comprehensive response to child sexual violence with specific emphasis on the clinical setting that includes:

- history taking and examination,
- management of physical injuries,
- prevention of disease and unwanted pregnancy,
- forensic examination and evidence collection,
- short and long term psychosocial support,
- medical documentation and follow up care.

4.2. Guiding principles for the health care provider

In order to provide comprehensive medical-forensic and psychosocial services, it is critical that HCPs recognize the international guiding principles in sexual violence. These principles ensure that any action taken by a HCP on behalf of the child survivor is supported by standards of care that will enhance the child’s health and well-being and avoid re-victimizing the child during the process of care. It is imperative that HCPs apply these principles in their day to day
management of child sexual violence. The principles include:

- Promoting the child’s best interest
- Ensuring safety
- Ensuring comfort and giving encouragement to the child
- Ensuring appropriate confidentiality
- Ensuring participatory decision making with the child survivor
- Ensuring fair and equal treatment, with no discrimination
- Strengthening the child’s resiliencies
- Ensuring that the health and welfare of the child takes precedence over the collection of evidence
- Using a “child-first” approach to care
- Note that it is crucial to minimize the number of persons who come into contact with the survivor in the course of care. This is to ensure adherence to the principles of GBV.

- An adolescent has the right to seek care without the consent of a parent/guardian.

4.3. Process Flow for the management of a child survivor of sexual violence within the clinical setting

The clinical care process map is intended to guide HCPs in following a sequence of steps to provide the appropriate type of clinical service that a child survivor of sexual violence should receive at each point of care in the continuum of comprehensive care within the health facility. The process map is outlined in Annex 1 with detailed content at each step provided in the standard operating procedures in the upcoming pages.
The sequence of steps to be followed in the provision of medical services include:

1. **Testing the survivor of CSV** – for STI, including HIV/AIDS; Pregnancy
2. **Examining the survivor** – Medical history of survivor of CSV, ‘top to toe’ examination, detailed genito-anal examination
3. **Treating the survivor of CSV** – treating injuries including treating STIs and PEP, EC, arranging referrals and follow-up care
4. **Record evidence of Injuries** – Description and classification of injuries, collection of forensic samples, documentation in relevant standard forms which can later be used in criminal proceedings
5. **Ensure safety of survivor of CSV** – notify police, child welfare officer

Where possible, the CSV champion should advocate with medical practitioners for free medical attention to be provided to CSV survivors.
5. **Health Facility Standards for the Management of Child Sexual Violence**

The focus in this section is specific to personnel, infrastructure and equipment required for provision of comprehensive CSV health services that include medical-forensic examination, laboratory services and counselling services. Children who have experienced SV may present at any point and time in the health system. Health facilities should therefore be prepared to receive and recognize any form of child SV and provide all necessary interventions. Where further medical-forensic examination or psychosocial services cannot be provided, a referral service should be instituted to the nearest medical facility that can offer advanced care. It is advised that referral occurs within 24 hours of first contact with a child survivor for timely interventions.

5.1 **Personnel**

The ideal approach to managing child SV is that both medical-legal and psychosocial services are provided simultaneously in the same location and as much as possible by the same trained, health care provider. A best practice would be to utilize an “on-call” schedule, whereby a designated person responds to the need for CSV services as and when required. Another best practice would be to have an updated directory of specific service providers in order to strengthen referral and linkages to child protection services.

5.2 **Infrastructure**

Infrastructure that enables a child-friendly service is critical throughout the cascade of care for CSV in all the sectors. At minimum the infrastructure should offer security, cleanliness, privacy and access to services by all, with the ultimate goal to keep the child safe from SV and harm. Medical-forensic examinations should take place at a medical facility where there is access to the full range of services required by the child survivor in accordance with the national guidelines on management of sexual violence in Kenya⁴.

5.3 **Equipment and Supplies**

The facility should be equipped to manage any acute medical conditions or emergencies and to offer a range of laboratory and counselling services. If the health facility does not offer these services there should be ready access to a range of medical-forensic services that may be required through

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**The service delivery point for child SV should:**

- Have an aesthetic lay out and is attractive to walk into
- Allow for both auditory and visual privacy e.g. a room with a door rather than curtains/screens.
- Be thermally neutral (neither too hot nor too cold)
- Be clean, with clean equipment and linen
- Have proper lighting e.g. fluorescent light that is neither too bright nor too dim
- Have immediate access to soap and clean water
- Have immediate access to a clean toilet and shower
- Have a table, desk, examination couch
- Have a phone where possible
- Have access to a separate support room for the caregiver or guardian

---
referral to service providers or reverse referral mechanisms where the service provider is called to provide the service at the health facility.

The essential equipment and supply requirements for providing CSV services include:

<table>
<thead>
<tr>
<th>A locally assembled evidence collection kit (rape kit) as recommended by the national programme</th>
<th>Evidence collection kits (syringes, empty sterile bottles, cotton swabs for collection of high vaginal specimens)</th>
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</thead>
</table>
| Essential Supplies: items that need to be replaced on a routine basis | • Forensic supplies: paper bags, evidence tape for sealing bags  
• Powder-free, nonsterile exam gloves  
• Sanitary towels  
• Wound management supplies  
• Culture supplies  
• Lubricant  
• Hospital gowns  
• Extra clothes for survivors whose clothes may be collected for evidence |
| Essential Equipment: capital equipment and durable items that last for several years | • Examination table/bed/stretcher that allows for positioning in lithotomy  
• Specula for children preferably for use in post-pubertal girls but where absolutely necessary can be used for examination of pre-pubertal girls  
• Waste disposal equipment  
• Handheld magnifying glass  
• Digital camera if possible - Facility capacity to store intimate images securely if obtained |
5.4. Medication

Essential medication required for management of child sexual violence include:

- Treatment for STIs
- Post Exposure Prophylaxis for HIV
- Emergency contraceptives (combined oral contraceptives, “morning after pills”, progesterone only pills)
- Tetanus Toxoid
- Analgesics
- Antibiotics

5.5. Documents

- Informed consent form
- PRC forms (MOH 363, Annexe 10)
- SGBV Register (MOH 364)
- Trauma Counselling Form
- Kenya Police Medical Form (P3)

**Examples of the SGBV register, Trauma counselling form, informed consent form and Kenya police medical form are annexed in the National Guidelines on Management of Sexual Violence in Kenya.**
6. **STANDARD OPERATING PROCEDURES FOR THE MANAGEMENT OF SURVIVORS OF CHILD SEXUAL VIOLENCE**

Standard operating procedures aid in translating the “what” in policies and guidelines into the “how” in service delivery in a structured format. These set of instructions aim to:

- Define or standardize procedures for clinical management of CSV
- Maintain good clinical practices
- Create a good quality health system for CSV
- Create an avenue for individual performance improvement for health care providers
- Improve institutional results and outcomes for CSV survivors

**Objective**

- To provide information about the processes and procedures that will take place during the course of management
- To seek permission from the child survivor and caregiver to carry out health services

**Guiding Principles**

When a child sexual violence survivor presents to a health facility, it is important that:

- Safety, privacy and confidentiality remain paramount during the course of clinical management
- Informed consent is obtained before conducting a full medical examination or providing psychosocial support
- Providers recognize consent as a process that continues throughout the examination and treatment
- The provider explains all aspects of the consultation and processes that the survivor will undergo during the course of their short-term and long-term recovery management
- It is explained that consent may be withdrawn at any time
- Consideration be given to capacity and age when determining who may consent for the exam of a child and where the child is too young a parent/caregiver/legal guardian as stipulated by law may give consent

The SOPs outlined in this section follow the critical steps of:

- Informed consent
- Medical-Forensic Examination
- Maintaining the chain of custody
- Psychosocial support
- Referral and Linkage

### 6.2. SOP 1: Taking consent from a child survivor of sexual violence

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<td>To provide information about the processes and procedures that will take place during the course of management</td>
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</tr>
</tbody>
</table>
Procedure

- Introduce yourself to the child survivor and caregiver if applicable
- If not at the service delivery point, escort the child survivor and caregiver to the designated service delivery point
- Assure the child survivor and/or caregiver of safety, privacy and confidentiality
- Put up appropriate signage to minimize interruption of the session
- Ensure all required medical equipment and tools for documentation are available
- Explain the processes and procedures that will take place during the course of management, making reference to the process flow map
- Establish the age of the child survivor to determine the type of consent that is to be sought.
- Depending on the child’s age, assent/consent shall be taken as follows:
  - 0-5 years – obtain informed written consent from the caregiver\(^1\)
  - 6 – 11 years - obtain oral assent from the child AND written consent using the nationally approved consent form, from a trusted caregiver\(^2\)
  - 12-14 years - obtain written assent from the child AND/OR written consent using the nationally approved consent form from a trusted caregiver OR written consent from an emancipated minor\(^2\)
  - 14 – 18 years - obtain written consent with child’s permission\(^3\)

Use nationally approved documents to document consent and file this in the child survivors’ file

Proceed with medical-forensic examination

1 Other trusted adult or case worker’s informed consent

2 Other trusted adult’s or child’s informed assent. Sufficient level of child’s maturity can take due weight

3 Child’s informed consent and sufficient level of maturity takes due weight
### Objective

- To obtain routine background and medical symptoms resulting from sexual violence
- To assess the nature, extent and severity of physical injuries

### Guiding Principles

- Life threatening injuries and extreme distress should take precedence over other aspects of the medical and forensic examination.
- Psychological first aid should be provided to the child and the caregiver at every step of the process until proper counseling can be conducted.
- Ensure informed consent has been obtained and documented
- If the survivor declines any part of the physical examination, you must respect her/his wishes. Giving the survivor autonomy over the process is important for the recovery process.

### Procedure

**Setting**

- Ensure that you are in the appropriate setting to carry out the medical-forensic examination
- Ensure privacy and safety for the child survivor
- Ask the survivor if he or she wishes to have the caregiver or family member present at the examination.
- Consider having another provider as a chaperone particularly if you are of different gender or the same gender as the perpetrator/s
- Explain to the survivor and/or caregiver all the steps and procedures you will be undertaking in this examination and the reasons why and show them the equipment that will be used
- Give them an opportunity to ask questions. Inform them that they are allowed to stop the procedure at any time.
**History taking**

- Document the history in the PRC form and client file
- Start by documenting the necessary demographic and administrative information AS PER THE POST-RAPE CARE FORM (MOH 363 PARTS A & B). Document additional notes in the client’s clinical file.
- Take your time with eliciting history from the SGBV survivor – use play therapy/drawings when necessary
- Document the history in the survivor’s own words for those old enough to talk (verbatim)
- Use neutral non-leading language, while remaining empathetic to the client
- Consider special circumstances – disabilities, conflict as you take the history
- Take an age specific history as follows:
  - 0 to 4yrs: From a non-offending guardian
  - 5 to 9yrs: Survivor + supplement with non-offending guardian
  - 10 to 18yrs: Survivor only (Non-offending guardian may be interviewed separately)
- Elicit the history on the incident and the circumstances surrounding the incident
  - Date and time of incident (if not given before give first dose of time sensitive medication like PEP and EC to non-pregnant pubertal girls if the 72 hour window is about to elapse)
  - Perpetrators-known or unknown to survivor/number/estimated age/gender
  - Place of incident and circumstances surrounding it
  - Type of sexual violence including if any penetration occurred, if condoms were used
  - Any struggle, any other related injuries
  - Reported to police? any other healthcare sought – and management given
  - Prior incidences – repeated assaults
  - Sexual history - Last consensual sexual intercourse
  - Obstetric and gynecological history should be elicited from female pubertal survivors – this should include: LMP, parity, contraception, known pregnant or lactating
  - Other prior medical or surgical history

Any additional information
### Forensic history

- Ask if the survivor changed their clothes and how the clothes were transported – paper or plastic bag and if they were handed over to the police
- Ask if the survivor went to the toilet or took a bath/cleaned themselves
- Find out and document if the survivor may have left any marks on the perpetrator

### Physical and Forensic Examination

- Reassure the survivor at every step of the examination and explain what you are going to do next
- Examine the survivor on a white sheet of paper either standing or on a couch
- Examine small children on the legal caregiver’s lap and consider sedation or general anaesthesia for small children especially if the injuries are expected to be severe
- **NEVER** force the child survivor to be examined

### Head to toe examination

- Take vital signs if these had not been taken at triage - temperature, RR, HR, height (cm) and weight (kg)
- Evaluate general appearance, hygiene and nutritional status
- Document the state of the clothes: (if the survivor is wearing the same clothes that were worn during assault) stains, tears, colour; collect and put all items in separate paper bags and label
- Determine sexual development stage that the child survivor is in
- Examine the mouth for bruising, tears, petechiae
- Document any bruises, cuts, inflammation and marks on the body outside the genitalia. Also look for healing injuries and scars that may indicate prolonged abuse
- Check for ligation marks on wrists and ankles as well and indicate all findings on the PRC form

### Positioning girls for genito-anal examination

- Try not to put the survivor in the position they were violated in to conduct the genito-anal examination – a left lateral position or knee chest position gives satisfactory view and often causes less distress than lying supine
- Examine infants or very young girls (under 5 years of age) either on an examining table or while on a parent’s/caregiver’s lap, while an assisting HCP positions the child and separates the child’s thighs
### Genito-anal examination for girls
- Examine for vulvar inflammations, eruptions, open lesions, tears, pain, and discharge and bruises to inner thighs and document
- Examine the patency of the hymenal orifice, size of the introital opening and the form and thickness of the hymen and document
- If there is discharge, determine the character, consistency, and color and the presence of any odor and make a point to collect the specimen for laboratory investigation
- Record the patency of anal sphincter bearing in mind that repeated anal penetration over a long period may cause a loose and an enlarged opening
- Document in the PRC form and in the survivor’s clinical file

### Positioning boys for genito-anal examination
- Try not to put the survivor in the position they were violated in to conduct the genito-anal examination
- The examination of external genitalia may be performed with the patient in the sitting, supine or standing position.
- Evaluation of the anus may be performed with the patient in the supine, lateral recumbent or prone position with gentle retraction of the gluteal folds

### Genito-anal examination for boys
- Examine the penis, testicles and perineum for bite marks, abrasions, bruising and lacerations
- Examine the anus for sphincter laxity, swelling, and mucosal tears, bleeding, sphincter spasm, discharge
- Check for skin tags that can form when tears heal
- Record the patency of anal sphincter - repeated anal penetration over a long period may cause a loose and an enlarged opening
- Document in the PRC form and in the clinical file

Proceed to carrying out forensic investigations and interventions as guided by the history and examination findings
### 6.4 SOP 3: Collecting forensic evidence and maintaining a credible chain of evidence

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure that evidentiary material is appropriately collected, documented, preserved and handed over to the police.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guiding Principles</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensure essential commodities for PRC are available</td>
</tr>
<tr>
<td>• For samples that require transportation ensure that this is done within stipulated times as recommended by the laboratory</td>
</tr>
<tr>
<td>• Bio-safety and infection control protocols must be maintained throughout to prevent contamination of (or by) laboratory samples</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forensic Investigations and interventions</td>
</tr>
<tr>
<td>• Take oral, external genital/labial swabs, high vaginal and/or anal swabs for microscopy, culture and sensitivity testing</td>
</tr>
<tr>
<td>• Ensure that at least 3 High Vaginal Swab (HVS) samples are collected. These should be air-dried before packing</td>
</tr>
<tr>
<td>• Collect urine for microscopy and to observe for: spermatozoa, culture and sensitivity, drugs and alcohol, and to conduct pregnancy testing</td>
</tr>
<tr>
<td>• Collect blood to determine haemoglobin level, HIV serology for child survivors older than 18 months, (for child survivors &lt; 18 months a DBS sample for DNA PCR should be collected), VDRL and Hepatitis B</td>
</tr>
<tr>
<td>• Collect pubic hair, nail clippings, foreign bodies</td>
</tr>
<tr>
<td>• Administer PEP, STI prophylaxis or treatment and EC for non-pregnant pubertal girls as per the national guidelines, if this has not been provided</td>
</tr>
<tr>
<td>• Document any surgical procedure such as suturing or surgical toilet that has been done</td>
</tr>
<tr>
<td>• Provide necessary vaccinations if indicated, as per the national guidelines laying specific emphasis on TT, Hepatitis B and HPV vaccines</td>
</tr>
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<table>
<thead>
<tr>
<th>Chain of Custody</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensure all samples are clearly labelled and packed appropriately away from environmental harm e.g. excessive heat</td>
</tr>
<tr>
<td>• Make a record of all samples taken and results in the laboratory register that should be kept locked away</td>
</tr>
<tr>
<td>• Sign and date the PRC form</td>
</tr>
<tr>
<td>• Contact the receiving police officer</td>
</tr>
<tr>
<td>• The receiving police officer should sign and date confirming that the forensic samples have been received</td>
</tr>
</tbody>
</table>
### 6.5 SOP 4: Providing Psychosocial Support

**Objective**
To identify the level of psychological trauma and provide psychosocial support and counselling for mental well-being.

**Guiding Principles**
- Psychosocial support forms an integral part of the survivor’s follow up, care and recovery; and can additionally provide more forensic information.
- It is recommended that age appropriate psychosocial support be instituted.
- Psychosocial support requires time and engagement of both the child survivor and their caregiver.
- Remember to document assent or consent by the survivor, the caregiver or both as per the consent taking SOP.
- Approach to psychosocial support may vary depending on the age and/or developmental stage (pre-pubertal/ pubertal).
- It is essential to explain all aspects of the consultation and process that the survivor is going to go through during the course of their management.
- It is recommended that an empathetic and non-judgmental approach to care is instituted.

**Procedure**
- Introduce yourself, lead to a designated child SGBV psychosocial support service delivery point, and create rapport with the child survivor and caregiver.
- Establish whether the survivor has received any health services elsewhere (PEP, ECP, STI management and PRC). If not, refer to clinician for medical-forensic management.
- Allow the child to familiarize themselves with the environment, giving them access to play or art material.
- Explain the process of counselling to the caregiver and/or older child survivor:
  - Aim of counselling and a debrief of expected processes and outcomes including approximate number of sessions the caregiver and survivor will require.
  - Issues to be covered (trauma counselling, HTS, adherence counselling, ECP, psycho-education, psycho-social support).
  - Provide information on child survivors’ rights, legal redress and referral linkages.
- Once the child is engaged in play or art, politely request the caregiver to step out of the room to a designated area, so as to engage with the child survivor.
- Carry out a social and/or risk assessment so as to determine the risk level or need for rescue services and a mental status examination.
### HIV Pre-test counselling

- Provide basic HIV information
- Explain benefits of HIV testing, the possible implications and the HIV testing process
- Conduct a risk assessment and ensure risk reduction while considering the survivor’s age, the HIV parental status for children under 5 years, the perpetrators’ HIV status if status is known
- Discuss the 72 hour window period, concerns around HIV testing, review the caregiver’s/survivor’s understanding and readiness for the test
- Conduct a HIV test, preferably as PITC as stipulated by the national HTS guidelines

### Post HIV test counselling

- Regardless of the outcome, assess the survivor’s/caregiver’s readiness for the results, provide results and discuss implications and risk reduction. Continue ongoing counselling
- For HIV negative results provide prevention counselling, continue trauma counselling, refer for additional support as required, initiate PEP and advice on repeat testing after 6 weeks
- For HIV positive results, initiate adherence counselling and link to HIV care for ART initiation; continue trauma counselling

### Adherence Counselling and Treatment literacy

- Discuss the treatment regimens and dosages for PEP/STI prophylaxis/ART
- Advise on side effects and their management and potential barriers to adherence
- Provide guidance on positive living, health consequences of STIs and other management e.g. TT vaccination, Hepatitis B vaccination, psychotherapy
- Emphasize on adherence to follow up care and appointment keeping
- Explain the importance of taking EC within 120 hours for female, pubertal child survivors

### Psycho-education

- Explore the survivor’s/caregiver’s issues, concerns and fears
- Identify and normalize feelings of guilt, embarrassment, low self-esteem and hopelessness
- Empower the survivor with information on coping mechanisms and tips on how to avoid situations which make them vulnerable to sexual violence in future
- Educate the caregiver on looking out for possible behavioral changes
### 6.6 SOP 5: Referral and linkages

#### Objective
To effectively utilize existing referral mechanisms for successful follow up care and integration/rehabilitation of the survivor back into the community

#### Guiding Principles
- Management of CSV requires a multi-disciplinary, as well as a multi-sectoral approach
- It is therefore important to recognize referrals and linkages as part of the continuum of care for a CSV survivor
- Referral and linkage tools should be available and up to date for complete documentation

#### Procedure
- Upon completion of the psychosocial session:
  - Counsellors should document the session’s findings and provide feedback to the clinician
  - Schedule joint follow up sessions for the child survivor and for the caregiver
  - Plan for home visits for further social assessment and reintegration
  - Conduct a post – psychological session assessment after at least 5 sessions to evaluate recovery progress
  - Upon reasonable medical and psychosocial improvement, prepare the child survivor and caregiver for termination from care with an open appointment
  - Plan for graduation from care and re-integration to community
  - Make recommendations for future follow up after termination from care has been made

---

**Psycho-social support**

- Offer group counselling as ongoing support for survivors and/or caregivers
- Family counseling should be offered where possible
- Refer for specialized psychological/psychiatric care
Client Flow Pathway for Treatment of Survivors of Sexual Violence

Survivor should be attended to as priority

**Survivor Entry**
- Outpatient department
  - Registration
  - Survivor debriefing
  - Triage

**Consultation**
- Informed consent
- History
- Examinations
- Specimen collection
- PRC form & P3 form
- Pre HIV test counseling
- 1st PEP dose

**Laboratory**
- HIV test
- Specimen analysis

**Counseling**
- Trauma counseling
- HIV test counseling
- Adherence counseling
- Follow-up sessions booking
- Psychosocial support groups
- Legal care and referrals

**Pharmacy**
- HIV Prevention Drugs (PEP) if HIV negative
- Emergency contraceptive
- Sexually Transmitted Infections (STI) drugs

- **HIV Positive**
- Comprehensive Care clinic
  - HIV care
  - ART
  - Psychosocial support

- **HIV Negative**
- Return/follow up visits

**Exit**

HIV, Sexually Transmitted infections and pregnancy can be prevented if Post Rape care services are provided within 72 hours of rape.

This publication was adopted from LVCT
The Setting for Clinical Services for Child Survivor of Sexual Violence

Consent/Assent received as per consent taking SOP → Ensure privacy and a safe environment → For older children/adolescents: ask the survivor if he or she wishes to have the caregiver or family member present at the examination

*consider having another provider as a chaperone particularly if you are of different gender or the same gender as the perpetrator/s

Explain to the survivor and/or caregiver all the steps and procedures you will be undertaking in this examination and the reasons why and show them the equipment that will be used

Give them an opportunity to ask questions. Inform them that they are allowed to stop the procedure at any time.

Start by documenting the necessary demographic and administrative information AS PER THE POST-RAPE CARE FORM and document in the patient file as well
**SOP for Taking Informed Consent For Child Survivor of Sexual Violence**

1. **Child Sexual Violence Survivor/Caregiver** presents to the facility

2. **Introduce yourself and lead to a designated CSV service delivery point**

3. **Explain the process of management to the patient (and/or caregiver) –**

4. **Establish the age of the CSV survivor, obtain and document consent/assent**

5. **Proceed to Medical-Forensic Examination**

- **0-5 years**
  - Obtain informed written consent from the caregiver

- **6-11 years**
  - Obtain an oral assent from the child AND written consent using the national approved consent from a trusted caregiver

- **12-14 years**
  - Obtain a written assent from the child AND/OR written consent using the national approved consent from a trusted caregiver OR written consent from an emancipated minor

- **14-18 years**
  - Obtain written consent with child’s permission

---

1. Other trusted adult or case worker’s informed consent
2. Other trusted adult’s or child’s informed assent. Sufficient level of child’s maturity can take due weight
3. Child’s informed consent and sufficient level of maturity takes due weight
History Taking SOP For Child Survivor of Sexual Violence

Elicit the history on the incident and the circumstances surrounding the incident as follows:

- Date and time of incident (if eligible give PEP and ECP if the window is about to elapse)
- Perpetrators-known or unknown to survivor/number/estimated age/gender
- Place of incident and circumstances surrounding the incident
- Type of sexual violence, penetration, use of condoms, foreign objects
- Any struggle, any other related injuries
- Report made to police or not. Any other healthcare sought and management given
- Prior incidences – repeated assaults
- Sexual history - Last consensual sexual intercourse
- Ob/Gyn history* –, LMP, parity, contraception, known pregnancies
- Other prior medical or surgical history
- Any additional information

Forensic history

- Ask if the survivor changed their clothes and how the clothes were transported - paper or plastic bag, and if they were handed over to the police
- Ask whether the survivor went to the toilet or took a bath/cleaned themselves
- Ask whether the survivor left any marks on the perpetrator

*Female survivors who are puberta

Age specific History taking protocol:

- 0 to 4yrs: Guardian
- 5 to 9yrs: Survivor + supplement with non-offending guardian
- 10 to 18yrs: Survivor only (nonoffending guardian may be interviewed separately)
# SOP for Performing a Physical Examination on Child Survivors of Sexual Violence

## Head to toe examination
- Take vitals if not taken at triage - temperature, RR, HR, height and weight
- Evaluate general appearance, hygiene and nutritional status
- Document the state of the clothes: stains, tears, colour; collect and put all items in separate paper bags and label (if same clothes were worn during assault)
- Determine sexual development
- Examine the mouth for bruising, tears, petechiae
- Document any bruises, cuts, inflammation and marks on the body outside the genitalia - Also look for healing injuries and scars that may indicate prolonged abuse
- Check for ligation marks on wrists and ankles as well and indicate all findings on the PRC form

## Positioning girls for genito-anal examination
- Try not to put the survivor in the position they were violated in to conduct the genito-anal examination – a left lateral position or knee chest position gives satisfactory view and often causes less distress than lying supine
- An infant or a very young girl can be examined either on the examining table or while on a parent’s lap, while the assisting nurse or the mother positions the child and separates the child’s thighs

## Positioning boys for genito-anal examination
- Try not to put the survivor in the position they were violated in to conduct the genito-anal examination
- The examination of external genitalia may be performed with the patient in the sitting, supine or standing position.
- Evaluation of the anus may be performed with the patient in the supine, lateral recumbent or prone position with gentle retraction of the gluteal folds

## Genito-anal examination for girls – examine and document in PRC form
- Check for any vulvar inflammations, eruptions, open lesions, tears, pain; and discharge and bruises to inner thighs
- Examine patency of the hymenal orifice, size of the introital opening and the form and thickness of the hymen
- If there is discharge, determine the character, consistency, and color; and the presence of any odor
- Examine the anal area as per genito-anal examination for boys

## Genito-anal examination for boys – examine and document in PRC form
- Examine penis, testicles and perineum for bite marks, abrasions, bruising and lacerations
- Examine anus for sphincter laxity, swelling, and mucosal tears, bleeding, sphincter spasm, discharge
- Check for skin tags that can form when tears heal
- Record the patency of anal sphincter - repeated anal penetration over a long period may cause a loose and an enlarged opening

##Forensic Investigations and interventions
- Forensic Investigations and interventions should be guided by history (refer to SOP2)
- Take oral, external genital, high vaginal and/or anal swabs for microscopy, culture and sensitivity
- Conduct urine test – for microscopy and spermatozoa, drugs and alcohol, and pregnancy test
- Test blood for HB, HIV, VDRL, Hep B  
- Always collect specimen in sets of three
- Blood sample for DNA analysis should be collected in a cotton wool and air dried
- Collect pubic hair, nail clippings, foreign bodies
- Give PEP, STI prophylaxis or treatment and PEP for non-pregnant pubertal girls if not given before
- Document any stitching or surgical toilet
- Administer vaccinations - TT, Hepatitis B, HPV

##Chain of Custody
- Ensure all samples/exhibits are packed appropriately and labelled
- Make a record of all samples taken and results in the laboratory register that should be kept locked away
- Sign and date the PRC form
- The receiving police officer should sign and date confirming that the samples have been received
### SOP for Performing a Physical Examination on Child Survivors of Sexual Violence

**Head to toe examination**

- Take vitals if not taken at triage - temperature, RR, HR, height and weight
- Evaluate general appearance, hygiene and nutritional status
- Document the state of the clothes: stains, tears, colour; collect and put all items in separate paper bags and label (if same clothes were worn during assault)
- Determine sexual development
- Examine the mouth for bruising, tears, petechiae
- Document any bruises, cuts, inflammation and marks on the body outside the genitalia - Also look for healing injuries and scars that may indicate prolonged abuse
- Check for ligation marks on wrists and ankles as well and indicate all findings on the PRC form

**Genito-anal examination for girls** - examine and document in PRC form

- Check for any vulvar inflammations, eruptions, open lesions, tears, pain; and discharge and bruises to inner thighs
- Examine patency of the hymenal orifice, size of the introital opening and the form and thickness of the hymen
- If there is discharge, determine the character, consistency, and color; and the presence of any odor
- Examine the anal area as per genito-anal examination for boys

**Positioning boys for genito-anal examination**

- Try not to put the survivor in the position they were violated in to conduct the genito-anal examination
- The examination of external genitalia may be performed with the patient in the sitting, supine or standing position.
- Evaluation of the anus may be performed with the patient in the supine, lateral recumbent or prone position with gentle retraction of the gluteal folds

**Genito-anal examination for boys** - examine and document in PRC form

- Examine penis, testicles and perineum for bite marks, abrasions, bruising and lacerations
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**Positioning girls for genito-anal examination**

- Try not to put the survivor in the position they were violated in to conduct the genito-anal examination – a left lateral position or knee chest position gives satisfactory view and often causes less distress than lying supine
- An infant or a very young girl can be examined either on the examining table or while on a parent’s lap, while the assisting nurse or the mother positions the child and separates the child’s thighs

### SOP for Collecting Forensic Evidence & Maintaining a Chain of Evidence on Sexual Violence

**Forensic Investigations and interventions**

- Forensic Investigations and interventions should be guided by history (refer to SOP2)
- Take oral, external genital, high vaginal and/or anal swabs for microscopy, culture and sensitivity
- Conduct urine test – for microscopy and spermatozoa, drugs and alcohol, and pregnancy test
- Test blood for HB, HIV, VDRL, Hep B,
  - Always collect specimen in sets of three
- Blood sample for DNA analysis should be collected in a cotton wool and air dried
- Collect pubic hair, nail clippings, foreign bodies
- Give PEP, STI prophylaxis or treatment and PEP for non-pregnant pubertal girls if not given before
- Document any stitching or surgical toilet
- Administer vaccinations- TT, Hepatitis B, HPV

**Chain of Custody**

- Ensure all samples/exhibits are packed appropriately and labelled
- Make a record of all samples taken and results in the laboratory register that should be kept locked away
- Sign and date the PRC form
- The receiving police officer should sign and date confirming that the samples have been received
SOP FOR PSYCHOSOCIAL SUPPORT FOR CHILD SURVIVORS FOR SEXUAL VIOLENCE

Explain the process of management to the patient (and/or caregiver) –

Establish whether the survivor has received any health services elsewhere (PEP, ECP, STI management and PRC). If not - refer to clinician for medical-forensic management

Allow the child to familiarize themselves with the environment, giving them access to play or art material

Once the child is engaged in play or art, politely request the caregiver to step out of the room to a designated area, so as to engage with the child survivor

Carry out a social and/or risk assessment so as to determine the risk level or need for rescue and a mental status examination

HIV Pre-test counselling
Provide basic HIV information
Explain benefits of HIV testing, the possible implications and the HIV testing process
Risk assessment and risk reduction considering the survivor’s age, the HIV parental status for children under 5 years, the perpetrators’ HIV status if status is known
Discuss the window period, concerns on HIV testing, review the caregiver’s/survivor’s understanding and readiness for the test.
Conduct a HIV test, preferably as PITC

HIV Post-test counselling
Regardless of the outcome - assess survivor’s/caregiver’s readiness for the results, provide results and discuss results implications and risk reduction. Continue on going counselling
For HIV negative results – prevention counselling, continue trauma counselling, referral to additional support, initiate PEP and advise on repeat testing after 6 weeks.
For HIV positive results – initiated adherence counselling and link to HIV care of ART initiation, continue trauma counselling

Adherence Counselling, treatment literacy and ECP
Discuss the treatment regimes and dosages for PEP/STI prophylaxis/ART
Side effects and their management and potential barriers to adherence
Positive living, health consequences of STIs and other management e.g. TT vaccination, Hep B vaccination, psychotherapy
Emphasize on follow up care appointment keeping
Explain the importance of taking EC within 120 hours for female, pubertal child survivors

Psycho-education
Explore the survivor’s/caregiver’s issues, concerns and fears
Identify and normalize feelings of guilt, embarrassment, low self esteem and hopelessness
Empower the survivor with information on coping mechanisms and tips on how to avoid situations which make them vulnerable to sexual violence in further

Psycho-social support
Offer group counselling as on going support for survivors and/or caregivers
Family counseling should be offered where possible
Refer for specialized psychological/psychiatric care

Explain the process of counselling to the caregiver and/or older child survivor:
- Aim of counselling and a debrief of expected processes and outcomes including approximate number of sessions the caregiver and survivor will require
- Issues to be covered (trauma counselling, HTS, adherence counselling, ECP, psycho-education, psycho-social support)
- Provide information on child survivors’ rights, legal redress and referral linkages
At the Facility
• Health care provider collects and documents data using most current client level data collection tool - PRC form (MOH 365)
• SGBV focal person fills the SGBV summary tool (MOH 364) at the end of the month and hands it over to the facility HRIO/Facility in-charge before 5th of the following month
• The facility HRIO/Facility in-charge sends the SGBV summary tool (MOH 364) to the Sub-county HRIO by 5th of the following month for entry into DHIS 2

At the Sub County
• The SCHRIO receives SGBV Summary (MOH 364) from all the facilities in the Sub County and checks for any data quality issues
• The SCHRIO addresses the identified data quality issues with assistance from the HROs of the facilities concerned before entering the data in DHIS 2
• The SCHRIO enters the SGBV data from all the facilities in the Sub County in DHIS 2 by 15th of the following month
• The SCHRIO holds quarterly data feedback meetings with SCHMT and other stakeholders to inform them of the SGBV status in the Sub county

At the County Level
• The CHRIO gets all the identified data quality issues addressed by the respective SCHRIOs by 20th of the following month
• CHRIO does reporting rate analysis for the Sub Counties in the County and gives feedback on the reporting rate
• The CHRIO uses the quarterly Data Review meetings to address data quality concerns for the facilities in the county
• Works with the Ministry of Health at the County to print and distribute SGBV data tools to the health facilities expected to report SGBV data set
• The CHRIO holds quarterly data feedback meetings with CHMT and other stakeholders in the County to inform them of the SGBV status in the County
生存者管理算法

**生存者紧急情况**

**是否被强奸？**

**医院**

在72小时内报告医院。

**艾滋病、性传播感染和怀孕**

如果在72小时内报告，可以预防艾滋病、性传播感染和怀孕。

**此出版物由LVCT采用。**

**免费专业咨询服务**

拨打1190寻求免费的专业咨询服务。

**应立即报告医院**

1. 报告医院进行：
   - 艾滋病预防（PEP）
   - 怀孕预防
   - 性传播感染治疗
   - 证据收集
   - 咨询

2. 报告警方并记录一份声明。

**切勿**

1. 不要洗澡或梳理头发。
2. 不要换衣服、洗澡或丢弃衣物，而是用军绿色包、清洁的布或布料包裹并带去医院。
3. 不要改变在性侵犯发生的地方。
4. 不要丢弃使用过的避孕套。
5. 不要排尿或排便，如果必须排尿，则收集在清洁容器中并带到医院。

**应做**

1. 立即接受艾滋病测试。
2. 如果测试呈阳性，停止PEP。
3. 继续服用PEP（2周）。
4. 艾滋病检测后4周、12周、24周。

**艾滋病预防**

**成人**

TDF 300mg + 3TC 300mg 一天一次 + LPVr 500mg 两天一次。

**儿童**

根据体重计算。

**随访期**

- 2周临床随访
- 2周PEP再鉴定
- 遵循性咨询

**咨询**

- 艾滋病
- 性病
- 怀孕
- 心理支持
- 药品
- 政府和非政府组织

**实验室**

- 详细信息
- 样本类型：医嘱或法医
- 检测结果：每项检测的指示

**处方**

- 艾滋病
- 性病
- 怀孕
- 心理支持
- 药品

**参考文献**

“肯尼亚性暴力管理国家指南”以及“肯尼亚抗逆转录病毒治疗指南”第四版2011年。

此出版物由LVCT采用。
**HAVE YOU BEEN RAPED?**

Report to the nearest hospital within 72hrs!

<table>
<thead>
<tr>
<th>DO’S</th>
<th>DON’TS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Report to the nearest hospital</td>
<td>1. <strong>DO NOT</strong> take a bath or comb your hair.</td>
</tr>
<tr>
<td>immediately for:</td>
<td></td>
</tr>
<tr>
<td>• HIV Prevention (PEP)</td>
<td>2. <strong>DO NOT</strong> change, wash or throw away your clothes, INSTEAD wrap</td>
</tr>
<tr>
<td>• Pregnancy prevention</td>
<td>them in a <em>khaki</em> bag, clean leso or cotton cloth and take them to</td>
</tr>
<tr>
<td>• Treatment of Sexually Transmitted</td>
<td>the hospital.</td>
</tr>
<tr>
<td>Infections</td>
<td>3. <strong>DO NOT</strong> change anything where the rape occurred.</td>
</tr>
<tr>
<td>• Collection of evidence</td>
<td>4. <strong>DO NOT</strong> dispose off a condom if one was used.</td>
</tr>
<tr>
<td>• Counseling</td>
<td>5. <strong>DO NOT</strong> pass urine or stool or wipe the genital area. If you must</td>
</tr>
<tr>
<td>2. Report to the police and record a</td>
<td>pass urine, collect some in a clean container and take it to the</td>
</tr>
<tr>
<td>statement.</td>
<td>hospital.</td>
</tr>
</tbody>
</table>

**HIV, Sexually Transmitted Infections and pregnancy can be prevented if you report to a hospital within 72 hours of the rape/sexual violence.**

**REMEMBER: IT IS NOT YOUR FAULT THAT YOU WERE RAPED. DO NOT FEEL GUILTY. DO NOT BE ASHAMED. DO NOT BLAME YOURSELF. TAKE ACTION AND REPORT TO THE NEAREST HOSPITAL!**

Call 1190 for free professional counselling following rape

This publication was adopted from LVCT
## Annex 11: Post Rape Care Form Template

**MOH 363**

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

---

### Post Rape Care Form

<table>
<thead>
<tr>
<th>Date</th>
<th>Day</th>
<th>Month</th>
<th>Year</th>
<th>Province Code</th>
<th>District Code</th>
<th>Facility Name</th>
<th>OP/IP No.</th>
<th>PRC reg. No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Date of birth</th>
<th>Day</th>
<th>Month</th>
<th>Year</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Contacts (Residence and Phone number)**

**Disabilities (Specify)**

**Orphaned vulnerable child (OVC)**

**Marital Status (specify)**

**Citizenship**

<table>
<thead>
<tr>
<th>Date and time of Examination</th>
<th>Day</th>
<th>Month</th>
<th>Year</th>
<th>Hr</th>
<th>Min</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date and Time of Assault</th>
<th>Day</th>
<th>Month</th>
<th>Year</th>
<th>Hr</th>
<th>Min</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of perpetrators</th>
<th>Male</th>
<th>Female</th>
<th>Estimated Age</th>
<th>Occupation of perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Place Assault Occurred /Where incidence occurred**

**Administrative location**

**Chief complaints / Presenting Symptoms**

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

**Type of Assault**

- [ ] Oral
- [ ] Vaginal
- [ ] Anal
- [ ] Other (specify)

**Use of condom?**

- [ ] Yes
- [ ] No

**Incident already reported to police?**

- [ ] No
- [ ] Yes

**Date and time of report**

<table>
<thead>
<tr>
<th>Day</th>
<th>Month</th>
<th>Year</th>
<th>Hr</th>
<th>Min</th>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Attended a health facility before this one?**

- [ ] No
- [ ] Yes

**Were you treated?**

- [ ] Yes
- [ ] No

**Were you given referral notes?**

- [ ] Yes
- [ ] No

**Significant medical and/or surgical history**

**General Condition**

<table>
<thead>
<tr>
<th>BP</th>
<th>Pulse</th>
<th>Rate</th>
<th>RR</th>
<th>Temp</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OB/GYN History**

<table>
<thead>
<tr>
<th>Parity</th>
<th>Contraception type</th>
<th>LMP Known</th>
<th>Pregnancy?</th>
<th>Date of last consensual sexual intercourse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Forensic**

<table>
<thead>
<tr>
<th>Did the survivor change clothes?</th>
<th>State of clothes (stains, torn, color, where were the worn clothes taken)?</th>
<th>Were the clothes put in a non-plastic paper bag?</th>
<th>Were the clothes given to the police?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did the survivor have a bath?</th>
<th>Did the survivor go to the toilet?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

**Long call? Short call?**

<table>
<thead>
<tr>
<th>Long call?</th>
<th>Short call?</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] No</td>
</tr>
</tbody>
</table>

**Does the survivor have any details on the assailant? Is the assailant known, is there any relation? Did the survivor leave any marks on the assailant?**

**Comments**

---

**MOH 363**

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

---

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

**Facility□Name□□□□□□□□□□□□□□□□□□□□□□PRC□reg.□No**

**Last□Name□First□Name Date□of□birth**

**Day□□□□□Month Year**

**Male**

**Female**

**Contacts□(Residence□and□Phone□number)□_____________________________________________________________**

**Place Assault□Occurred□/Where□incidence□occurred□___________________________________**

**Administrative□location□________________________________________________________**

**Chief□complaints□/□Presenting□Symptoms**

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

**Type□of□Assault□Use□of□condom?□**

- [ ] Yes
- [ ] No

**Incident□already□reported□to□police?**

- [ ] Yes
- [ ] No

**Attended□a□health□facility□before□this□one?□Were□you□treated?**

- [ ] Yes
- [ ] No

**Were□you□given□referral□notes?**

- [ ] Yes
- [ ] No

**Significant□medical□and/or□surgical□history**
<table>
<thead>
<tr>
<th>OB /GYN History</th>
<th>Parity</th>
<th>Contraception type</th>
<th>LMP</th>
<th>Known Pregnancy?</th>
<th>Date of last consensual sexual intercourse</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Condition</td>
<td>BP</td>
<td>Pulse Rate</td>
<td>RR</td>
<td>Temp</td>
<td>Demeanor /Level of anxiety (calm, not calm)</td>
</tr>
</tbody>
</table>

**Forensic**

<table>
<thead>
<tr>
<th>Did the survivor change clothes?</th>
<th>State of clothes (stains, torn, color, where were the worn clothes taken)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Were the clothes put in a non-plastic paper bag?</th>
<th>Were the clothes given to the police?</th>
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<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Did the survivor have a bath?</th>
<th>Did the survivor go to the toilet?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Long call?</td>
</tr>
<tr>
<td>No</td>
<td>Short call?</td>
</tr>
</tbody>
</table>

Comments:

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

<table>
<thead>
<tr>
<th>Genital Examination of the survivor - indicate discharges, inflammation, bleeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe in detail the physical status.</td>
</tr>
<tr>
<td>Physical injuries (sign in the body map)</td>
</tr>
<tr>
<td>Outer genitalia</td>
</tr>
<tr>
<td>Vagina</td>
</tr>
<tr>
<td>Hymen</td>
</tr>
<tr>
<td>Anus</td>
</tr>
<tr>
<td>Other significant orifices</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>----------</td>
</tr>
</tbody>
</table>

Immediate Management

<table>
<thead>
<tr>
<th>PEP 1st dose</th>
<th>ECP given</th>
<th>Stitching /surgical toilet done</th>
<th>STI treatment given</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Yes (No of tablets)</td>
<td>Yes</td>
<td>Yes(Comment)</td>
<td>Yes(Comment)</td>
</tr>
</tbody>
</table>
**MOH 363**

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

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

<table>
<thead>
<tr>
<th>Sketch of person</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior view</td>
<td></td>
</tr>
<tr>
<td>Posterior view</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Female Genitalia</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Male Genitalia</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Type</td>
<td>Test</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Outer Genital swab</td>
<td>Wet Prep Microscopy</td>
</tr>
<tr>
<td>Anal swab</td>
<td>DNA</td>
</tr>
<tr>
<td>Skin swab</td>
<td>Culture and sensitivity</td>
</tr>
<tr>
<td>Oral swab</td>
<td></td>
</tr>
<tr>
<td>Specify</td>
<td></td>
</tr>
<tr>
<td>High vaginal swab</td>
<td>Wet Prep Microscopy</td>
</tr>
<tr>
<td>Urine</td>
<td>Pregnancy Test</td>
</tr>
<tr>
<td></td>
<td>Microscopy</td>
</tr>
<tr>
<td></td>
<td>Drugs and alcohol</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Blood</td>
<td>Haemoglobin</td>
</tr>
<tr>
<td></td>
<td>HIV Test</td>
</tr>
<tr>
<td></td>
<td>SGPT/GOT</td>
</tr>
<tr>
<td></td>
<td>VDRL</td>
</tr>
<tr>
<td></td>
<td>DNA</td>
</tr>
<tr>
<td>Pubic Hair</td>
<td>DNA</td>
</tr>
<tr>
<td>Nail clippings</td>
<td>DNA</td>
</tr>
<tr>
<td>Foreign bodies</td>
<td>DNA</td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
</tr>
</tbody>
</table>

**Chain of custody**

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

<table>
<thead>
<tr>
<th>To</th>
<th>Signature</th>
<th>Day</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>By</th>
<th>Signature</th>
<th>Day</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
References

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