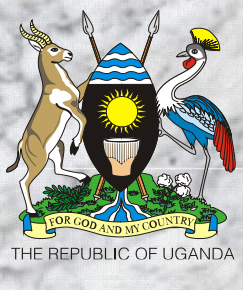

THE REPUBLIC OF UGANDA

Training of Health Workers on Prevention and *Management of Sexual and Gender Based Violence and Violence Against Children*

Trainee Manual

November, 2018

Acknowledgment

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Dr. Jane Ruth Aceng,

Director General of Health Services

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Abbreviations and acronyms used in this Curriculum

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CEDAW	Convention on Elimination of all forms of Discrimination Against Women
CPD	Continuous Professional Development
DNA	Deoxyribonucleic Acid
DT	Diphtheria and Tetanus Toxoids
DTP	Diphtheria and Tetanus Toxoids and Pertussis vaccine
DVA	Domestic Violence Act
ECP	Emergency Contraceptive Pills
ELISA	Enzyme-linked Immunosorbent Assay
FGM	Female Genital Mutilation
GBV	Gender Based Violence
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
IPV	Intimate Partner Violence
IUD	Intrauterine Device
OPD	Out Patient Department
PCA	Penal Code Act
PEP	Post-Exposure Prophylaxis
PTSD	Post-Traumatic Stress Disorder
RPR	Rapid Plasma Regain
S/GBV	Sexual and gender based violence
STI	Sexually Transmitted Infection
Td	Tetanus Toxoid and reduced Diphtheria Toxoid
TIG	Tetanus Immunoglobulin
TT	Tetanus Toxoid
UNICEF	United Nations Children's Education Fund
UNFPA	United Nations Fund for Population Activities
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary Counselling and Testing (for HIV)
VAC	Violence Against Children
WHO	World Health Organization

Glossary of Terms

Anxiety	Anticipation of future threat
Adolescent	Any person aged between 10 and 19 years
Child	A child according to the constitution of the Republic of Uganda is an individual human being aged less than 18 years.
Child Sexual Abuse	The involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child or adolescent is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.
Child neglect	Means the failure to provide for the basic physical, emotional and developmental needs of a child, in areas such as health, education, emotional development, nutrition, shelter and safe living conditions, which cause or have high probability of causing impairment to a child's health or physical, mental, spiritual, moral or social development (Section 2 Children (Amendment) Act, 2016).
Defilement	This is unlawful sexual interactions with a child under the age of eighteen years; a girl or boy by any person man or woman including fellow child.
Emotional health	Refers to the ability to appropriately express emotions
Fear	This refers to the emotional response to real or perceived imminent threat
GBV	Gender-Based Violence is the term used to distinguish common violence from violence that targets individuals or groups of individuals on the basis of their gender. It includes acts that inflict physical, mental or sexual harm or suffering, threat of such acts, coercion, and deprivations of liberty, directed to an individual on basis of their gender.
Gender	Socially expected characteristics including roles and responsibilities of men and women, girls and boys in a given community and they differ/vary from society to society, and keep changing time to time.

Intimate partner violence	Refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours.
Mental Health	Refers to the ability to properly think and process information
Psychiatry	A branch of medicine that deals with the study of abnormal mind/brain functioning
Psychosocial	Refers to psychological (mind, psychic, mental) and social (way of life)
PTSD	A psychiatric disorder that can occur following the experience or witnessing life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents, physical or sexual assaults in adult or childhood.
Rape	Rape is unlawful carnal knowledge of a woman aged 18 years and above, without her consent, or with her consent, if the consent is obtained by force or by means of threats or intimidation of any kind or by fear of bodily harm, or by means of false representations as to the nature of the act, or in the case of a married woman, by personating her husband.
S/GBV	Sexual and gender based violence has been defined by the CEDAW committee as violence directed at a person on the basis of gender or sex with sexual intent or affecting the sexual development and or functioning of an individual.
Sexual violence	Is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object."
Survivor	The preferred term for a person who has lived through an incident of violence (S/GBV and VAC).
Trauma	An injury (as a wound) to living tissue caused by an extrinsic agent. Or A disordered psychic or behavioural state resulting from severe mental or emotional stress or physical injury.
Violence	Is defined by the World Health Organization as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury,

	death, psychological harm, mal-development, or deprivation
Victim	A person who has suffered an incident of violence (S/GBV and VAC) and continues to live it.

Purpose of this Manual

1. To provide National Standardized Materials for training Nurses, Midwives, Medical Officers, Clinical Medical Officers and other relevant stakeholders involved in the prevention and management of Sexual and Gender Based Violence (S/GBV)/Violence Against Children (VAC) survivors/victims.
2. To serve as the basis for teaching Nurses, Midwives, Clinical Medical Officers, Medical Officers and other health professional trainees so as to respond appropriately to conditions related to Sexual and Gender Based Violence/Violence Against Children. It is relevant for both pre and in-service training.
3. To provide a training resource for all players in health institutions and other organizations involved in training service providers in prevention and management of survivors/victims of Sexual and Gender Based Violence/Violence Against Children as a component of the Minimum Health Care Package.

How the Manual is organized

The Curriculum is divided into 7 main modules namely: Module 1-Overview of Gender-Based Violence and Violence Against Children; Module 2–The Law and S/GBV and VAC, Module 3–Communication, Psychosocial and Mental Health Counselling in S/GBV and VAC, Module 4 - Clinical Management of S/GBV and VAC Survivors/victims; Module 5-Networking and Social Mobilisation for Sexual and Gender Based Violence/Violence Against Children; Module 6-Monitoring and Evaluation; Module 7 – Prevention.

These modules are intended to complement one another. However, each of them can be taught independently if necessary. All service providers should be oriented on all of them. The modules aim at helping nurses, midwives, doctors, clinical medical officers, laboratory personnel, social workers and other health practitioners develop into practitioners who are able to think critically and make appropriate prevention and management decisions on the basis of sound knowledge and understanding of the different areas of work related to S/GBV and VAC including the necessary networks in the community. . Nonetheless, it is assumed that midwives, clinical officers and other health professional trainees who undertake training using the modules have basic skills such as history taking and general examination of patients for example measuring blood pressure, performing a vaginal examination, etc.

Users of This Manual

The users of this manual are:

I) In-service trainers in Government and Non-Government Institutions who have a responsibility of training service providers in prevention and Management of Sexual and Gender Based Violence and Violence Against Children.

ii) Pre-service Trainers/Tutors and Clinical Instructors in Pre-service schools of nursing, midwifery, clinical officers, medical officers and other health professionals.

iii) Preceptors and service providers while guiding trainees during training or when conducting on-the-job training for colleagues.

iv) Other stakeholders working in government, private institutions and NGOs for self-learning self-assessment and continuous professional development (CDP).

v) Medical officers, midwives, clinical medical officers trained in S/GBV and VAC for self-update and self-assessment of knowledge, skills and attitudes gained during training.

Facilitators/Trainers:

The facilitators of these modules will be trained and competent service providers who will include health workers, police officers, social workers, legal and education officers a who have undergone a two-weeks training in *Basic Training/Precepting Skills Course* and have ability to pass on knowledge and skills to others.

Facilitators and preceptors should be well endowed with knowledge, skills and working experience in prevention and management of S/GBV and VAC.

Training Goal and Objectives

Goal:

To equip nurses, midwives, medical officers, clinical medical officers, laboratory personnel and other stakeholders with competencies to prevent and manage S/GBV and VAC survivors/victims.

Broad Training Objectives:

- Develop knowledge and skills of health workers in S/GBV and VAC prevention and management.
- Manage survivors/victims of S/GBV and VAC using the National Clinical Guidelines.
- Equip health workers and other stakeholders with abilities to establish and maintain linkages/referral and partnerships for effective S/GBV and VAC prevention and management.
- Acquaint health workers and other stakeholders with knowledge and procedures to facilitate legal redress for survivors/victims S/GBV and VAC.

Specific Training Objectives:

By the end of the course, participants will be able to:

1. Describe the concepts and current magnitude of S/GBV and VAC.
2. Routinely screen all clients for S/GBV and VAC.
3. Counsel S/GBV and VAC survivors/victims, their families and friends.
4. Provide psychosocial counselling and mental health support to S/GBV and VAC survivors/victims, families and friends.
5. Establish and maintain relevant networks/linkages for S/GBV and VAC prevention and management.
6. Accurately collect, store and use S/GBV and VAC data.
7. Apply appropriate procedures for legal redress of S/GBV and VAC survivors/victims.
8. Evaluate the training.

Objectives of the practicum or simulation session

By the end of the practicum, trainees will be able to perform the following minimum required clinical procedures:

Clinical Procedures	**No. of cases to be managed by each trainee**
1. Follow appropriate steps in medical treatment of S/GBV and VAC survivors/victims	2
2. Prepare the survivors/victims for management	1
3. Complete a consent form	2
4. Take history	1
5. Collect forensic evidence as necessary (Procedures/Simulation) using the Sexual Assault kit or available equipment/supplies	1
6. Conduct physical, genital and Anal examination	1
7. Counsel S/GBV and VAC survivors/victims	2
8. Provide PEP	1
9. Offer emergency contraception	1
10. Manage STIs	1
11. Manage a child survivor/victim	1
12. Document S/GBV and VAC findings and ensure confidential storage of information	1
13. Completely fill and issue a medical certificate	1
14. Conduct follow-up visit for survivors/victims	3
15. Refer as necessary	1

Post-Training Tasks for the S/GBV and VAC Service Provider:

1. Identify and screen S/GBV and VAC survivors/victims
2. Recognize and manage complications of S/GBV and VAC and refer appropriately for management
3. Establish and monitor interpersonal relationships with GBV survivors/victims and their families
4. Collect, preserve, store and maintain chain of custody for forensic evidence materials
5. Identify and describe methods and channels of community mobilization
6. Offer counselling to survivors/victims of S/GBV and VAC, suspected perpetrators and their families/friends.
7. Document S/GBV and VAC cases and ensure confidential storage of data
8. Be able to appropriately fill the police forms when required
9. Refer S/GBV and VAC survivors/victims appropriately and link them to various social networks and legal services.
10. Prepare to testify in court when called upon
11. Establish linkages and partnerships for GBV management

Workshop Programme

Sunday		Monday	Tuesday	Wednesday	Thursday	Friday
Reporting date	8.30– 9.30 a.m.	Climate setting	Recap of previous day's work	Recap of previous day's work Collecting forensic evidence	Recap of previous day's work Psychosocial Counselling and Mental Health Support	POST TEST
	9.30-10.30 am	Elements of gender concepts	Communication and Counselling Skills	Collecting forensic evidence	Psychosocial Counselling and Mental Health Support	Legal framework on S/GBV and VAC
10.30 – 11.00 a.m. B R E A K						
	11.00 am– 12.00p.m.	Overview of S/GBV and VAC	Communication and Counselling skills	Performing physical and genital examination	The Role of Health Workers in Social Mobilisation for S/GBV and VAC	Legal framework on S/GBV and VAC
	12.00– 1.00p.m	S/GBV and VAC as Public Health problem	Introduction to Clinical Management of S/GBV and VAC	Performing physical and genital examination	Counselling to survivor/Victim	Legal Framework on S/GBV and VAC
1.00 - 2.00 p.m L U N C H						
	2.00 – 3.30 p.m.	Gender and human rights issues in S/GBV and VAC	Making preparation for medical examination	Treatment and Use of Management Protocols	Introduction to Networking	Presentation of Back home application plans
	3.30 – 5.00 p.m.	The Guiding Principles	Preparing a survivor/Victim for examination	Counselling after Care	Networking	Sharing of the post-test results Evaluation of Training
4.00 - 4.00 p.m T E A B R E A K						
	4.30 – 5.30 p.m.	Routine Screening for GBV	Taking history	Follow-up	Data Management Monitoring and Evaluation	Closure of the Workshop
		Evaluation of the day	Evaluation	Evaluation	Introduce Back home Application Plans	Report Writing

MODULE 1
OVERVIEW OF SEXUAL AND GENDER BASED VIOLENCE AND VIOLENCE AGAINST CHILDREN

DESCRIPTION OF THE MODULE:

This unit will introduce participants to concepts and terms commonly related to Sexual and Gender Based Violence and Violence Against Children to enable standardized understanding. These terms and concepts will be used/applied throughout all the units of this curriculum. Participants will be helped to appreciate the magnitude of sexual and gender and based violence/Violence against children globally and in Uganda; citing examples and sharing experiences. Gender and Human Rights issues in S/GBV and VAC prevention and management will be explored as well as the relationship between gender and health, the causes and effects/consequences of S/GBV and VAC to enable participants to understand the urgent need for basic minimum response services in all settings and by different players.

MODULE OBJECTIVES

1. Describe the terms and concepts related to gender, gender based violence and violence against children
2. Appreciate the magnitude of sexual and gender based violence/violence against children globally and in Uganda.
3. Describe S/GBV and VAC as a public health problem
4. Describe gender and human rights issues in S/GBV and VAC prevention and management
5. Outline guiding principles in relation to prevention and management of S/GBV and VAC

Session 1.1: Introduction to Gender Based Violence and Violence Against Children

Session Objectives:

By the end of this session, participants will be able to:

1. Explain the terms and concepts related to gender, gender based violence and violence against children
2. Explain the relationship between gender and health
3. Discuss the global magnitude of gender based violence and violence against children
4. Explain the causes of gender based violence and violence against children
5. Describe the forms of gender based violence and violence against children
6. Discuss the consequences of sexual and gender based violence/violence against children on health and development

Terms and Concepts related to Gender

Definition of Gender:

Gender is broadly defined as the socially ascribed characteristics of men and women in society.

Sex, on the other hand, refers to the physiological and biologically determined characteristics of men and women.

Differences between sex and gender

Sex	Gender
▪ Biologically defined	▪ Socially constructed
▪ Determined (seen) at birth	▪ Differs between and within cultures
▪ Universal	▪ Includes variables identifying differences in roles, needs, responsibilities, opportunities, and constraints
▪ Relatively fixed (unless by surgical/ hormonal interventions	▪ Subject to change and evolution as society evolves
▪ Set by nature	▪ Varies from one society to the next, depending on age, class, religion, economy, politics

Gender is:

- ***Relational*** – because women and men do not live in isolation; gender refers to the relationships between the man and woman and how these relationships are socially constructed. Often there is a misconception that when we speak of gender, it is to the exclusion of men.
- ***Hierarchical*** – because the differences established between women and men are far from—neutral and tend to attribute greater importance and value to—masculine characteristics –which often results in unequal power relationships.
- ***Historical***–because gender or gender norms are nurtured by factors that change over time and space, therefore can be modified through interventions.
- ***Contextually specific***–because variations in gender relations depend on ethnicity, age, sexual orientation, religion, etc. – therefore it is important to incorporate diversity.
- ***Institutionally structured***– social relations are supported by values legislation, religion and they are upheld by social systems.

Gender Based Violence and Violence Against Children

What is Gender Based Violence?

The term gender based violence is used to distinguish common violence from violence that targets individuals or groups of individuals on the basis of their gender. *Sometimes the term Gender Based Violence is used interchangeably with sexual and gender based violence and violence against women.*

What is Violence Against Children

This means any form of physical, emotional or mental injury or abuse, neglect, maltreatment and exploitation, including sexual abuse, intentional use of physical force or power, threatened or actual, against an individual which may result in or has a high likelihood of resulting injury, death, psychological harm, mal-development or deprivation (Section 2 Children (Amendment) Act, 2016).

Concepts of Gender Based Violence and Violence Against Children

Power

Power is the capacity or ability to direct or influence the behaviour of others or the course of events. This can be real or perceived power i.e. perpetrators of SGBV/VAC can have real or perceived power. Some examples of different types of power and powerful people include social peer pressure, bullying, leader, teacher, parents.

Real Power:

Is a commission of an unlawful act done in an official capacity which affect the performance of official duties. For example, forced sex with a subordinate, corporal punishments for children

Perceived power

The extent to which a person feels able to enact the behaviour.

Forms of power

Economic	The perpetrator controls money or access to goods / services / money / favours; sometimes husband and parents
Political	Elected leaders, discriminatory laws and policies
Physical	Strength, size, use of weapons, controlling access or security; soldiers, police, robbers, gangs
Gender-based (social)	Males are usually in a more powerful position than females
Age-related	Often, the young and elderly people have the least power

Everyone has power and it can be used positively or negatively

Power is directly related to choice. The more power one has, there are more choices available. The less power one has, fewer choices are available.

Un-empowered people have fewer choices and are therefore more vulnerable to abuse.

Violence involves the abuse of power. Unequal power relationships are exploited or abused.

Violence

The act that causes pain in mind or body. Violence is defined by the World Health Organization as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation Violence denies people their human rights, which are in born.

We should never say "the person deserved it" or that "violence is acceptable".

- Violence consists of the use of physical force or other means of coercion such as threat, inducement or promise of a benefit to obtain something from a weaker or more vulnerable person.
- Using violence involves forcing someone to do something against her/his will—use of force.

Force- might be physical, emotional, social or economic in nature. It may also involve coercion or pressure. Force also includes intimidation, threats, persecution, or other forms of psychological or social pressure. The target of such violence is compelled to behave as expected or to do what is being requested, for fear of real and harmful consequences.

Consent:

- Consent means saying—yes, agreeing to something. Informed consent means making an informed choice freely and voluntarily by persons in unequal power relationship.
- Acts of gender based violence/Violence against children occur without informed consent. Even if s/he says yes, this is not true consent because it was said under duress, the perpetrator(s) used some kind of force together to say yes.
- Children (under age 18) are deemed unable to give informed consent for acts such as female genital mutilation (FGM), marriage, sexual relations, etc.

NOTE: *Consent does not necessarily have to be expressed. It can be mistakenly given.*

Survivor/Victim is the preferred term for a person/child who has lived through an incident of gender based violence/violence against children.

- The word victim conjures an image of someone who is weak, sick, small, hunched over, crying, and clothed in rags, unable to function in the world. It is a sad, disempowering word.
- The word—survivor/Victim conjures an image of someone who stands straight and tall, uses eye contact, walks with confidence, lives life to the fullest. It is a powerful, empowering word.

Survivors/victims can include:

The following categories are more vulnerable to violence/abuse

- Children especially Unaccompanied Minors (UAMs), fostered children
- Women because they are usually second class, culturally considered inferior
- Unaccompanied females, without male protection
- Single women, female headed households
- Mentally and/or physically disabled females and males
- Economically disempowered people
- Junior staff males and females, students, less privileged community members
- Minority groups; e.g. ethnic, religious, low literacy levels
- Asylum-seekers and Internally displaced persons

A perpetrator

This is a person, group, or institution that inflicts, supports, or condones violence or other abuse against a person or group of persons. *Perpetrators could be:*

- Persons with real or perceived power
- Persons in decision-making positions
- Persons in authority

***Categories* or groups of people who are potential perpetrators:**

- Intimate partners (husbands, boyfriends)
- Influential community members (teachers, leaders, politicians, religious leaders)
- Security forces, soldiers, peace-keepers
- Humanitarian aid workers (international, national, refugee staff)
- Strangers and friends
- Members of the community
- Relatives (brothers, uncles, parents, aunts, sisters, etc.)
- Anyone who is in a position of power

Relationship between gender and health

GENDER ROLES:

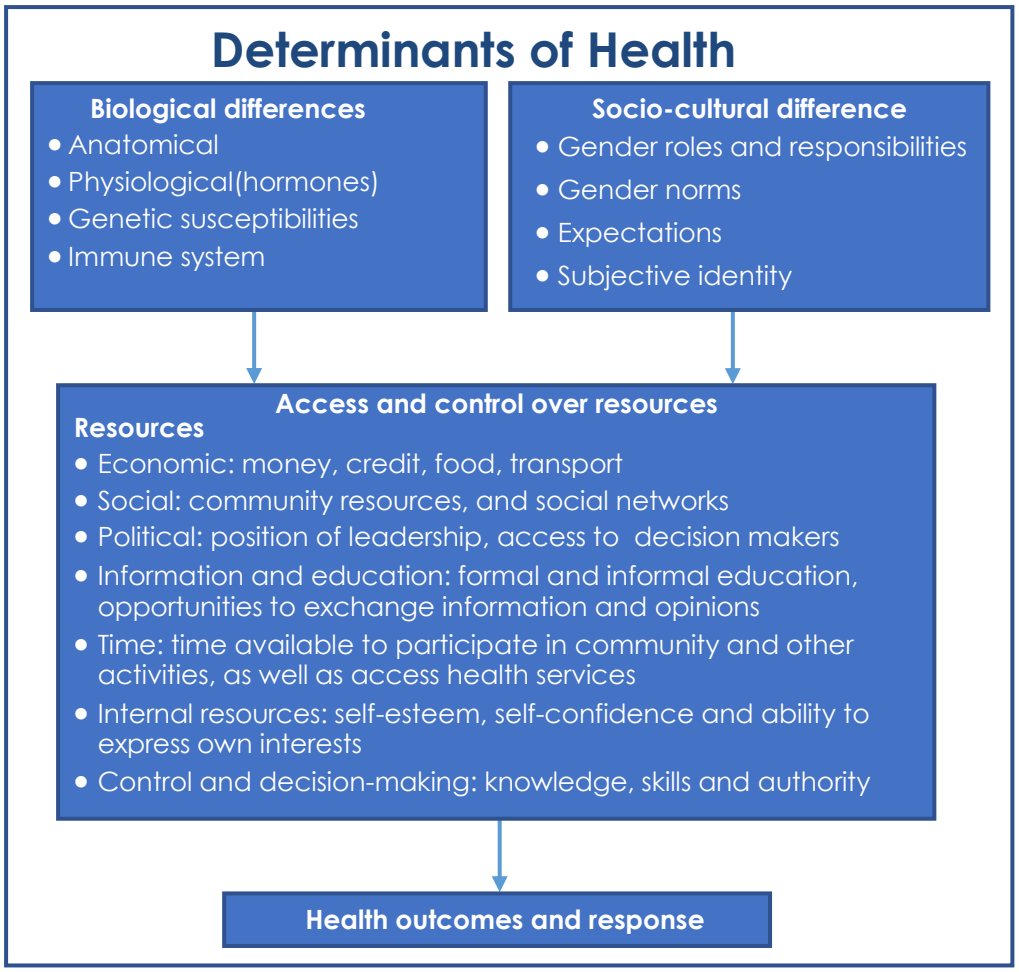
Gender roles define what is considered appropriate for men and women within the society, social roles and division of labour. They involve the relation to power (how it is used, by whom and how it is shared). This varies greatly from one culture to another and change over time and from one social group to another within the same culture. Roles are influenced by race, class, religion, ethnicity, economic circumstances and age. They are transformed by sudden crisis such as HIV/AIDS, war or famine can radically and rapidly change gender roles. Gender roles foster power imbalances between men and women.

GENDER AND HEALTH

Definition of health

Health is defined by WHO as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Gender is important in health because biological factors, social, cultural differences, access and control of resources by women and men, have an influence on health outcomes. [Fig.1 below]

The determinants of Health i.e. Biological factors, socio and cultural difference between women and men, access and control of resource can interact, influence health outcomes and response as shown in the diagram below.



The Global Magnitude of Sexual and Gender Based Violence/ Violence Against Children

Sexual and Gender Based Violence

The global average prevalence rates for violence against women (physical or sexual) aged 15-49 is estimated at 35.6 percent and the regional (Africa) average is 37.7 percent (WHO). In Uganda, the percentage of women and men age 15-49 who have ever experienced sexual violence is 21.9% and 8.3% respectively, (Uganda DHS, 2016).

- Violence against women – particularly intimate partner violence and sexual violence – is a major public health problem and a violation of women's human rights.
- Global estimates published by WHO indicate that about 1 in 3 (35%) of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.

Intimate partner violence

This refers to ongoing or past violence and abuse by an intimate partner or ex-partner (a husband, boyfriend or lover) either current or past

- Most of the violence experienced by women is intimate partner violence. Worldwide, almost one third (30%) of women who have been in a relationship report that they have experienced some form of physical and/or sexual violence by their intimate partner in their lifetime.
- Globally, as many as 38% of murders of women are committed by a male intimate partner.
- Intimate partner violence is the most common form of violence faced by women in Uganda. It is most common among women in the Eastern and Northern regions of Iteso ethnicity, Pentecostal women, and rural women. (UDHS 2016)

Physical violence

- 56% of all women aged 15 – 49 years have ever (i.e. in their lifetime) experienced physical violence by any perpetrator.
- 27% of women have experienced physical violence by an intimate partner in the past 12 months currently.

Sexual violence

It is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object."

- 21.9% of all women aged 15 – 49 years have ever (i.e. in their lifetime) experienced sexual violence by any perpetrator or partner (Uganda DHS 2016).
- 35.9% of ever-married women (15-49) who experienced intimate partner violence suffered one or more injuries (Uganda DHS 2016)

Sexual gender based violence accounts for at least 50% of the cases within the criminal justice system as illustrated below:

Crime Category	2016	2015	2014	2013	2012
Death (Dom/Violence)	163	178	144	150	131
Defilement	17,567	17,812	18,507	19,508	17,216
Rape	1,572	1,548	1,419	1,365	1,139
Indecent Assault	548	760	668	769	970
Incest	72	93	99	79	67
Domestic Violence	10,744	7,939	7,703	8,363	7,304
H/Trafficking (Women)	375	219	77	60	27

Violence Against Children

This means any form of physical, emotional or mental injury or abuse, neglect, maltreatment and exploitation, including sexual abuse, intentional use of physical force or power, threatened or actual, against an individual which may result in or has a high likelihood of resulting injury, death, psychological harm, mal-development or deprivation (Section 2 Children (Amendment) Act, 2016).

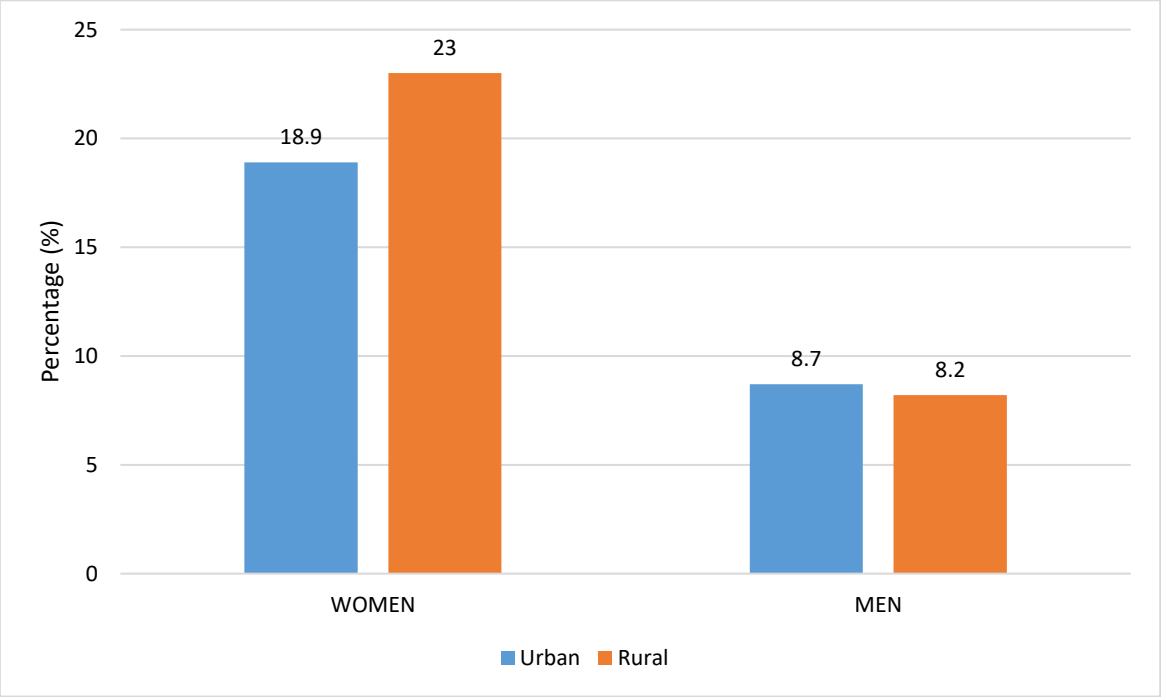
Magnitude of VAC in Uganda

Age	Type of violence	Girls	Boys
18-24	Physical violence	59%	68%
13-17	Physical violence	44%	59%
18-24	Sexual violence	35%	17%
18-24	Emotional violence	34%	36%

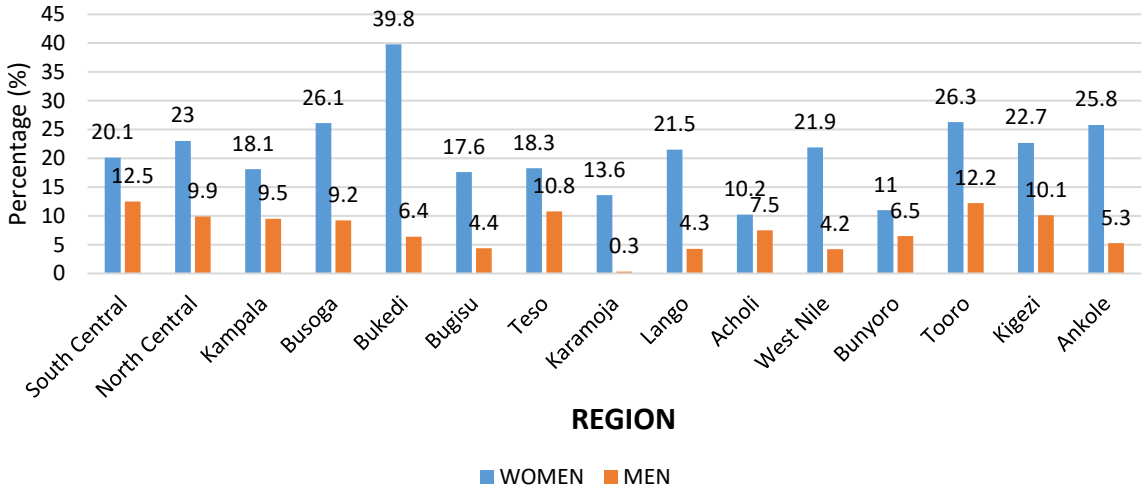
Source: UNICEF VAC report for 2018

VIOLENCE AGAINST MEN AND WOMEN IN UGANDA

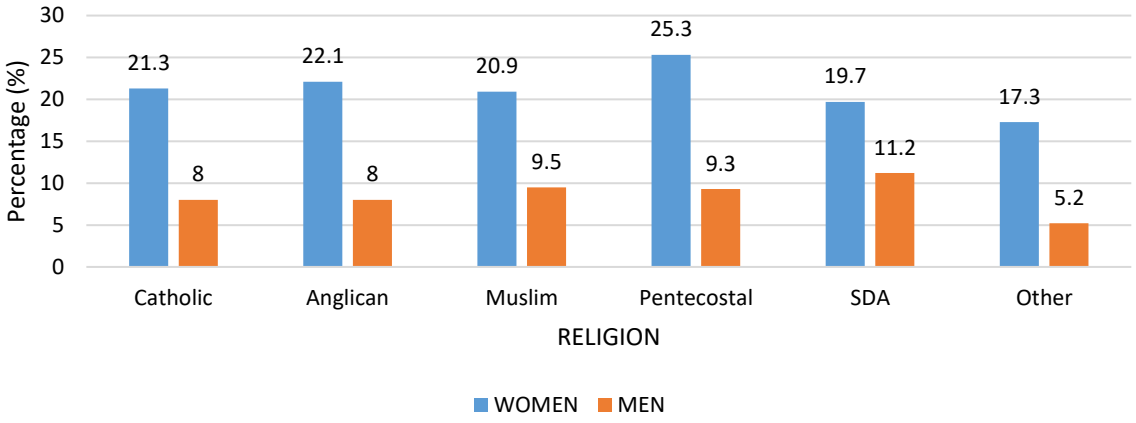
Percentage of women and men age 15-49 who have ever experienced sexual violence according to Residence (Uganda DHS 2016)



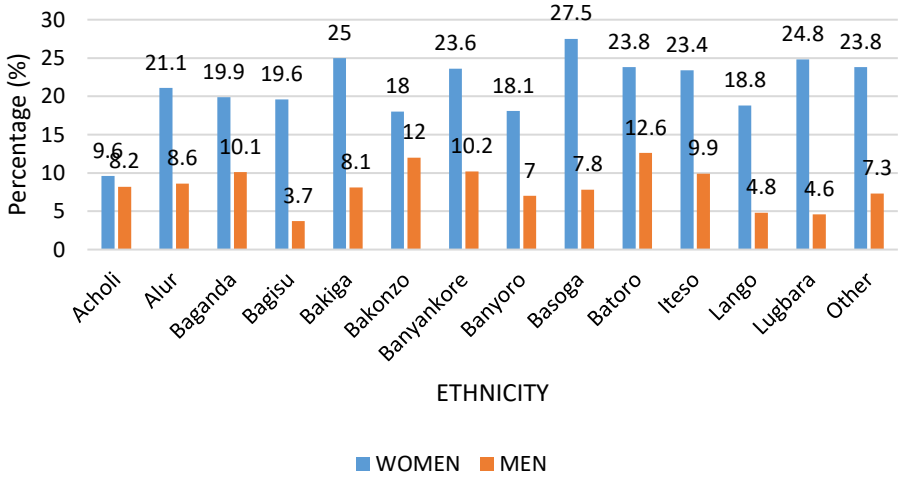
Percentage of women and men age 15-49 who have ever experienced sexual violence according to Region (Uganda DHS 2016)



Percentage of women and men age 15-49 who have ever experienced sexual violence according to Religion (Uganda DHS 2016)



Percentage of women and men age 15-49 who have ever experienced sexual violence according to Ethnicity (Uganda DHS 2016)



Types of VAC

There are four main types of violence against children:

- Physical abuse
- Sexual abuse
- Psychological or emotional abuse
- Neglect

Child physical abuse

Is defined as non-accidental physical injury caused by punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child, which is inflicted by a parent, guardian, caregiver, stranger, or any other person.

Differences between physical abuse and disciplining a child

In physical abuse, unlike physical forms of discipline, the following elements are present:

	Physical abuse	**Disciplining a child**
Action	Unpredictable	Predictable
Reason	May be known or unknown to the child The child never knows what is going to set the parent/ caregiver off	Child always knows what may trigger punishment
Extent	Unlimited	Done within the limits of parenting
Effect	Instills fear in the child The child constantly lives in fear and is never sure what behavior will trigger a physical assault.	Educates the child
Motive of the person punishing or abusing the child	Done out of anger and the desire to assert control The angrier the parent/ caregiver, the more intense the abuse.	Motivation to lovingly teach the child.

Note: Parents/caregivers who are physically abusive may believe that their children need to fear them in order to behave, so they use physical abuse to "keep their children in line." However, what children are really learning is how to avoid being beaten, not how to behave or grow as responsible individuals.

Child emotional abuse

- Emotional abuse means the emotional ill-treatment of a child that causes severe and persistent adverse effects on the child's emotional development.
- It can include seeing or hearing the ill-treatment of another. This involves;
  - Conveying to children that they are worthless, unloved, inadequate, or valued only in so far as they meet the needs of another person
  - Age or developmentally inappropriate expectations
  - Causing children frequently to feel frightened or in danger
  - Exploitation or corruption of children.

Child sexual abuse

It is an illegal sex act performed against a minor by an adult. (Blacks Law dictionary 8th edition).

- Forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. This may include physical contact or involving children in looking at or in the production of sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse.
- It must be reported by all community members including health workers, social workers, community, political, traditional and religious leaders.
- The dynamics of child sexual abuse differ from those of adult sexual abuse. In particular, children rarely disclose sexual abuse immediately after the event. Moreover, disclosure tends to be a process rather than a single episode and is often initiated following a physical complaint or a change in behavior.
- Definitive signs of genital trauma are seldom seen in cases of child sexual abuse. The accurate interpretation of genital findings in children requires specialist training and, wherever possible, experts in this field should be consulted.

Every child has a right to be protected against all forms of violence including sexual abuse and exploitation, child sacrifice, child labor, child marriage, child trafficking, institutional abuse, female genital mutilation and any other forms of abuse.

It further states that any person who believes that a child is being abused, neglected or under imminent danger of being abused or injured may report the matter to the designated authority. Reporting is mandatory for medical practitioners, social workers teachers and community members with regard to children under their care (S.42A Children (Amendment) Act.

Child neglect

This refers to the failure to provide for the basic physical, emotional and developmental needs of a child, in areas such as health, education, emotional development, nutrition, shelter and safe living conditions, which cause or have high probability of causing impairment to a child's health or physical, mental, spiritual, moral or social development(Section 2 Children (Amendment) Act, 2016).

Child neglect can occur in the following parental/caregiver conditions/situations:

- Physical inability to care for a child such as an adult with a serious injury;
- Mental inability to care for a child such as an adult with untreated depression or anxiety;
- Alcohol or drug abuse that results in the adult's serious impairment of judgment and the ability to keep a child safe;
- Lack of knowledge of basic care needs of children at different developmental ages;
- Poverty/insufficient funds; and
- Lack of knowledge that emotional nurture is an essential need of children.

Neglect may be physical, for example:

- Failure to provide necessary food or shelter
- Lack of appropriate supervision
- Abandonment (i.e., children who were left by their parents/guardians without information and were not claimed).

Neglect may be medical, for example:

- Failure to provide necessary medical or mental health treatment
- Refusal of health care for a child
- Exposure to risk of infection
- Delay in seeking/providing health care for a child
- Prenatal exposure to neglect.

Neglect may be educational, for example:

- Failure to educate a child or attend to special education needs

Neglect may be emotional, for example:

- Inattention to child's age appropriate emotional needs
- Failure to provide psychological care
- Permitting the child to use alcohol or other drugs.

Child trafficking

This means recruitment, transportation, transfer, harboring or receipt of a child by means of threat or use of force or other forms of coercion, abduction or fraud, deception, abuse of power, or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation (Section 2 Children (Amendment) Act, 2016).

Child pornography

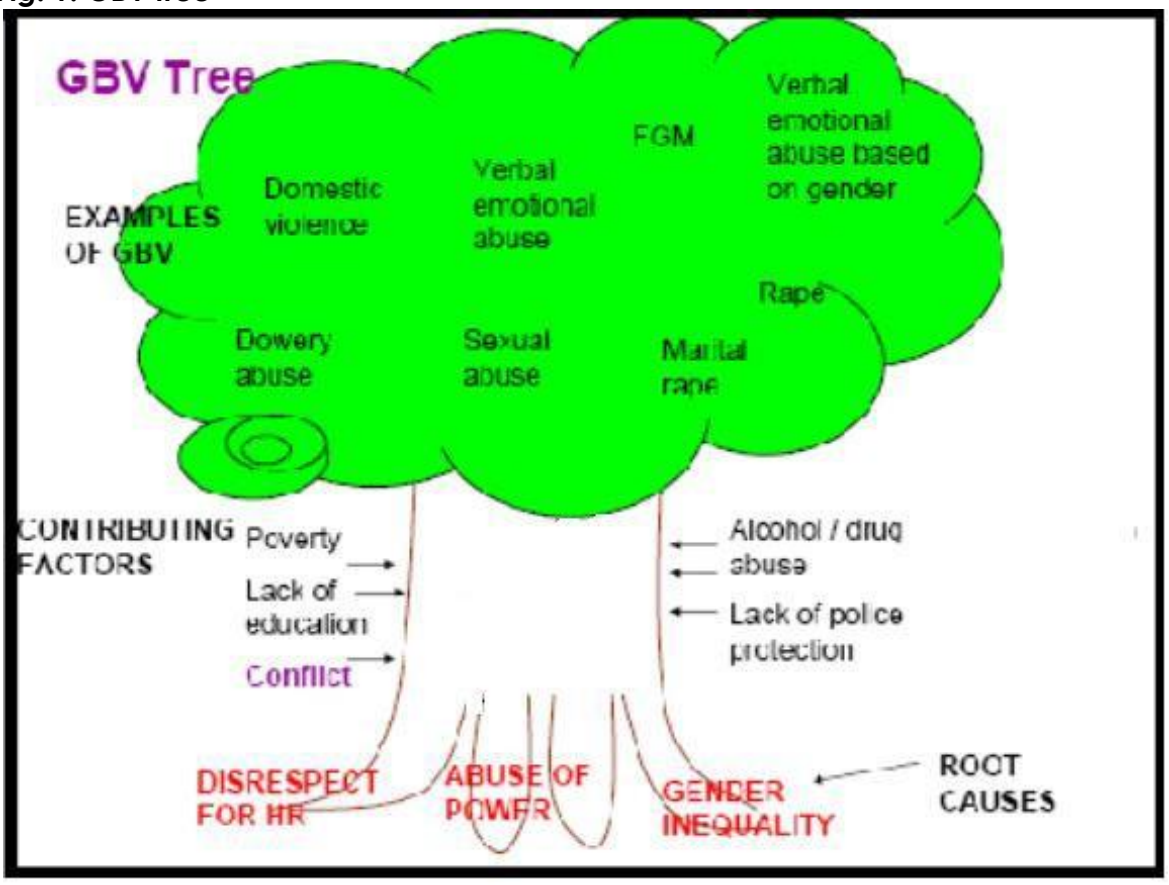
This means any representation through publication, exhibition, cinematography, indecent show, through information technology or by whatever means, of a child engaged in real or simulated explicit sexual activity, or any representation of sexual parts of a child from primarily sexual purposes (Section 2 Children (Amendment) Act, 2016).

Child exploitation

This means the employment of a child in activities from which other people derive a benefit, whether financial, sexual or political and includes activities such as child trafficking, child prostitution, child pornography and involvement of children n armed conflict (Section 2 Children (Amendment) Act, 2016).

Causes of Gender Based Violence

Fig. 1: GBV tree



At the ***individual*** level, the degree of knowledge, personal security, access to and control of resources, services and social benefits, personal history and attitudes towards gender can influence whether a person will become a victim/survivor/Victim or a perpetrator of violence.

NOTE: To be or not to be violent is an individual's choice.

Relationship, represents the immediate context in which abuse can occur: between individuals, even within families. At this level, existing power inequalities among individuals begin to reinforce subordinate/privileged positions.

The ***community*** level represents the dynamics between and among people that are influenced by socialization within such local structures as schools, health care institutions, peer groups and work relationships. For refugees, this structure is found in the refugee camp or setting, where the availability of and access to social services and the very layout of the camp can have a direct impact on whether or not incidents of Sexual and Gender-Based Violence occur.

Society includes the cultural and social norms about gender roles, attitudes towards children, women and men, the legal and political frameworks that govern behaviour, and the attitude towards using violence as means of resolving conflicts. It is clear to see that changes in behaviour and attitudes in any one of the areas can have an impact on all of them. Interventions to prevent or respond to Sexual and Gender Based Violence should thus target all levels.

Predisposing factors:

a) Individual risks

- Loss of security such as loss of social support, physical protection among others
- Dependence
- Physical and mental disabilities
- Lack of alternatives to cope with changes in socio-economic status
- Alcohol, drug use/abuse
- Psychological trauma and stress of conflict, flight, displacement
- Disrupted roles within family and community
- Ignorance/lack of knowledge of individual rights enshrined under national and international law

b) Social norms and Values

- Discriminatory cultural and traditional beliefs and practices
- Religious beliefs
- General insensitivity and lack of advocacy campaigns condemning and denouncing Gender-Based Violence

Coercion can encompass:

- Varying degrees of force;
- Psychological intimidation
- Blackmail; or
- Threats (of physical harm or of not obtaining a job/grade etc.)

In addition, sexual violence may also take place when someone is not able to give consent–for instance, while intoxicated, drugged, asleep or mentally incapacitated or in case of a child.

c) Challenges in the legal system

These more commonly apply to sexual violence:

- Reluctance by victims of S/GBV and VAC and their care-takers to report S/GBV and VAC
- Cultural and traditional norms, customs and practices that condone S/GBV and VAC
- Poor collection, handling and recording of forensic evidence by health workers
- Reluctance by the health workers to cooperate with police and judiciary while handling legal process of S/GBV and VAC.
- The practice of settling matters of S/GBV and VAC out of court
- Lack of facilitation for health workers to go to court
- Difficulties in establishing age of survivor/Victim and suspects
- Lack of awareness on availability of medical services like PEP, ECP, etc. by the victims and community.
- Victim's lack of awareness of their rights

NOTE: The Constitution recognizes marriages contracted through customs that promote payment of bride price/wealth as a condition of marriage. This in essence promotes S/GBV and VAC since the woman is taken as property and held at ransom if she or her parents are not able to pay back the bride price in case the marriage fails.

d) War, armed conflict and break down of social structures

- Exertion of political power and control over other communities
- Socio-economic discrimination
- Refugee, returnee and internally displaced situations
- Collapse of social and family support structures
- Geographical location and local environment (high crime areas and IDP camps)
- Design and social structure of IDP camps (overcrowded, multi-household dwellings, communal shelter)
- Gender insensitive services and facilities in the camps (predominantly male camp leadership; gender-biased decisions)

- Unavailability of food, fuel, income generation, leading to movements in isolated areas
- Limited number of police officers to offer protection

Forms of gender based violence

- Physical
- Sexual
- Psychological
- Economic
- Harmful Traditional Practices

Examples of Physical abuse/Violence

Type of Act	Description /Example	Can be perpetrated by
Physical assault	Beating, punching, kicking, biting, burning, maiming or killing, with or without weapons;	Spouse, intimate partner, family member, friend, acquaintance, stranger, anyone in position of power, members of parties to a conflict
Aggravated trafficking, trafficking and slavery	Selling and/or trading in human beings for forced sexual activities, forced labour or services, slavery or practices similar to slavery, servitude or removal of organs.	Any person in a position of power or control.

Examples of Sexual Violence: Sexual violence may occur without the use of force.

Type of Act	Description /Example
Rape and marital rape	The current law: Any penetration of the vagina by the penis, without consent. Rape is committed by a man against woman. A woman cannot rape a man. If any other object other than the penis is used to penetrate the vagina, the current law charges the offender under— Offences against nature but not Rape.
Child sexual abuse	Any act where a child is used for sexual gratification.
Defilement	Any contact on the sexual organ, anus, mouth by any object (fingers, bottles). It can be committed by anybody. Both boys and girls can be defiled A child cannot consent to any sexual act of any nature **Note:** *For defilement of a child below the age of 14 years it is aggravated defilement.*

Type of Act	Description /Example
Incest	Any sexual relations /interaction with a blood or legal relative
sodomy/anal sex	Anal sexual intercourse, usually male-to-male or male-to-female.
Attempted rape or attempted sodomy/ anal sex	Attempted forced/coerced intercourse; no penetration.
Sexual abuse	Actual or threatened physical intrusion of a sexual nature, including inappropriate touching, by force or under unequal or coercive conditions.

Examples of Psychological/ Emotional

Type of Act	Description /Example	Can be perpetrated by
Verbal Abuse or Humiliation	Non-sexual verbal abuse that is insulting, degrading, demeaning; compelling the victim/survivor to engage in humiliating acts, whether in public or private; denying basic expenses for family survival.	Anyone in a position of power and control; often perpetrated by spouses, intimate partners or family members in positions of authority.
Confinement	Isolating a person from friends/family, restricting movements, deprivation of liberty or obstruction/ restriction of the right to free movement.	Anyone in a position of power and control; often perpetrated by spouses, intimate partners or family members in a position of authority.

Examples of Socio-Economic Violence

Type of Act	Description /Example
Discrimination and/or denial of opportunities, services	Exclusion, denial of access to education, health assistance or remunerated employment; denial of property rights.
Honour killing and maiming	Maiming or murdering a woman or a girl as punishment for acts considered inappropriate for her gender that are believed to bring shame on the family or community, or as a way to preserve the honour of the family, or as a redemption for an offence committed by a male member of the family
Infanticide and/or neglect	Killing, withholding food, and/or neglecting female children because they are considered to be of less value in a society than male children.

Health Consequences of Sexual and Gender Based Violence/Violence Against Children

The health consequences of S/GBV and VAC include serious short- and long-term physical, mental, sexual and reproductive health problems for women, men and adolescents. The health consequences affect children, and lead to high social and economic costs for women, their families and societies. Such consequences can include;

Fig. 2: Health Consequences and Impact of S/GBV and VAC

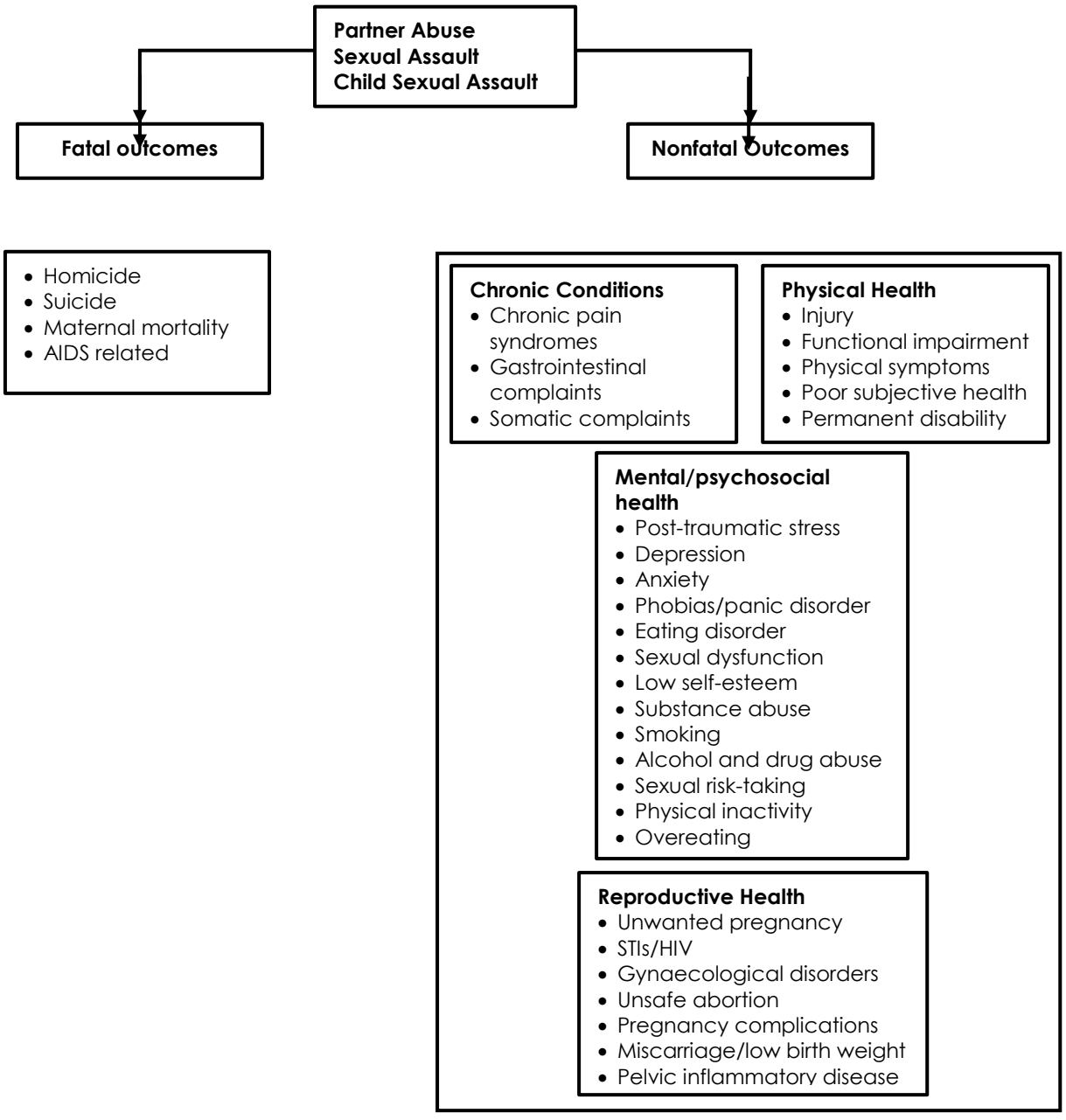


Fig. 2 above depicts the short-term and the long-term effects of S/GBV and VAC on a female. Long-term indirect consequences are also shown to demonstrate that the act of violence will continue to have negative repercussions for the duration of her life.

Intimate partner violence has also been associated with higher rates of infant and child mortality and morbidity (for example diarrheal diseases and malnutrition).

Social and economic costs

The social and economic costs of intimate partner and sexual violence are enormous and have ripple effects throughout society. Women may suffer isolation, inability to work, loss of wages, lack of participation in regular activities and limited ability to care for themselves and their children.

The WHO information tool on violence notes that mental torture and living in fear and terror were undoubtedly the worst and most profound and long-lasting aspect of S/GBV and VAC perpetrated against women. It has become increasingly clear that S/GBV and VAC adversely affects women's lives and well-being. However, the manifestations of S/GBV and VAC often go undetected and for a large number of women they may continue living through repeated abuse and assault without any recognition of their ordeal or adequate provision for care or support.

Session 1.2: S/GBV and VAC as a Public Health Problem

Session Objectives:

By the end of this session, participants will be able to:

1. Identify where S/GBV and VAC occurs and people at risk ;
2. Discuss the roles and responsibilities of health workers in addressing S/GBV and VAC.

S/GBV and VAC occurs in all homes communities, urban or rural, poor or rich and does not exempt any social class, religion or ethnicity and age

Where does S/GBV and VAC occur?

a. In families; physical and psychological violence including battering, defilement, sexual abuse of children in the household, dowry related violence, marital rape, female genital mutilation, and traditional harmful practices to women, non-spousal violence and violence related to exploitation.
b. In communities; physical, sexual and psychological violence including rape, female genital mutilation, traditional harmful practices, polygamy, early marriage, defilement, harmful religious practices sexual abuse, sexual harassment, and, trafficking of women, children and forced prostitution, child labour.
c. In work places; physical, sexual and psychological violence perpetrated or condoned by the state wherever it occurs, Intimidation at work, in education institutions, and elsewhere.
d. Violence perpetrated by the state; failure to pass, disseminate and implement policy against S/GBV and VAC,
e. In schools where physical, sexual and psychological violation of learners and students by their own teachers, support staff and administrators

People at risk:

Although S/GBV and VAC is a global phenomenon in terms of age and sex, there are certain groups of people who are at a higher risk of S/GBV and VAC. These include: -

a) Children

Children are vulnerable to S/GBV and VAC because they are weak and an easy target of perpetrators of S/GBV and VAC. In addition, there are cultural beliefs that endanger the safety of children like female genital circumcision (FGM); the presumption that they are HIV negative and that the perpetrator is not at risk of acquiring HIV; having sex with children can heal HIV and that having sexual intercourse with children rejuvenates old men.

b) Women

Women of all age-groups and social status are prone to S/GBV and VAC. This is mainly due to the socially ascribed roles that expect women to be submissive, seek

protection from their husbands or male members of the family, and ascribe them to be second-class citizens NOT equal players in homes.

Even among women there are sub-categories of women who are more prone to S/GBV and VAC than others such as pregnant women and female heads of households.

Pregnant women may be deprived of essential needs like food leading to malnutrition in pregnancy.

- They have little or no control over the family purse to the extent that even in emergency situations, they have to seek permission from their spouses or mothers –in-law to get treatment. The power relations in the home are against pregnant women so much that they have no mandate to make decisions on their own health like attending scheduled antenatal clinics or eating appropriately fortified foods. Despite pregnancy, they are expected to continue working in the farms and taking care of all other members of the family.
- Those that are HIV-positive are at a high risk of S/GBV and VAC where disclosure of results may lead to accusations of being promiscuous and may lead to physical abuse and/or abandonment in the home.
- They may also be stigmatized for not breastfeeding their infants thus suffering emotional abuse not only from their spouses but other family members.

c) Elderly

Elderly women and men are at high risk of S/GBV and VAC because they are weak targets for perpetrators. Fear of stigmatization from the community may bar them from reporting S/GBV and VAC. They may suffer S/GBV and VAC from their social peers and in-laws or family members.

d) Mentally disabled

People with mental disability may lose perception of their surroundings and suffer memory loss. They are prone to S/GBV and VAC because of their condition such as wondering to foreign environments, being desolate from the general public and being neglected from care and support.

e) People with physical disabilities.

Disability: is any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being. The restriction compromises the individual's ability to resist or defend oneself, raise alarm, runaway, or report. For example; the lame and crippled, deaf and dump; blind, etc.

f) Adolescents

They have peculiar desires and experiences in relation to the biological and sexual changes that occur during adolescence. For instance, they desire to learn more about their new changes, some may aspire to experiment sex with a misguided view of proving their vitality. Misconceptions about sexuality like the more sexual

partners you have the bigger the size of the penis or if a girl doesn't have sex then she will not get married, may close or become very hard. Adolescents are prone to defilement and sexual abuse by close family members, people in positions of authority such as teachers, among others.

The role of health workers in addressing S/GBV and VAC:

- Help survivors/victims feel welcome, safe, and free to talk.
- Ask survivors/victims about abuse whenever violence is suspected.
- Assess a survivor/Victim /victim's immediate danger, help him/ her develop a safety plan, and refer him/her to community resources.
- Provide appropriate care.
- Offer counselling to survivors/victims of S/GBV and VAC, perpetrators and their families/friends in a non-judgmental, sensitive and supportive manner.
- Recognize and manage complications of S/GBV and VAC and manage/refer appropriately.
- Establish and monitor interpersonal relationships with S/GBV and VAC survivors/victims and their families.
- Collect and preserve forensic evidence materials.
- Identify and describe methods and channels of community mobilization.
- Refer S/GBV and VAC survivors/victims appropriately and link them to various social networks and legal services.
- Document the woman's condition and ensure confidential storage of data
- Prepare to testify in court when called upon
- Routinely screen for GBV.
- Sensitisation of community members, parents and teachers about S/GBV and VAC

Why health workers should be concerned with Sexual-Gender Based Violence and Violence Against Children?

1. SS/GBV and VAC is a major cause of disability and death among women and men, adolescents and children.
2. S/GBV and VAC has adverse consequences for women's sexual and reproductive health such as limiting women's ability to negotiate safe sex.
3. If they do not ask about violence, providers may misdiagnose victims or offer inappropriate care.
4. Health care providers are strategically placed to identify people at risk of S/GBV and VAC.
5. Health professionals are in a unique position to change societal attitudes about S/GBV and VAC.
6. Responding to S/GBV and VAC violence can improve the overall quality of health care.
7. Health professionals may inadvertently put people at risk if they are uninformed or unprepared.

(International Parenthood Federation, 2005

Session 1.3: Guiding Principles in responding to S/GBV and VAC

Session objectives:

By the end of the session, participants will be able to:

1. Discuss the guiding principles in relation to S/GBV and VAC management
2. Demonstrate ability to uphold the guiding principles

Guiding principles in relation to S/GBV and VAC management

Safety:

- Ensuring the safety and security of the survivor/Victim /victim should be the number one priority for all actors, at all times. Remember that the survivor/Victim may be frightened and need assurance of her individual safety. In all cases, ensure that she is not at risk of further harm by the perpetrator or by other members of the community.
- If necessary, ask for assistance from camp security, authorities, field officers, or others.
- Be aware of the safety and security of the people who are helping the survivor/Victim such as family, friends, community service or S/GBV and VAC workers, and health care staff.

Confidentiality:

- At all times, respect the confidentiality of the survivor/victim's families.
- Share only necessary and relevant information (not all details), ONLY if requested and agreed by the survivor/Victim, with only those people involved in providing assistance.
- Information about S/GBV and VAC reported incidents and S/GBV and VAC survivors/victims should never be shared if it includes the individual's name or other identifying information. Information concerning the survivor/Victim should only be shared with third parties after seeking and obtaining the survivor/victim's (or their parents, 'in the case of children) explicit consent in writing.
- All written information must be maintained in secure, locked files.
- In meetings, there may be times when a specific S/GBV and VAC case is mentioned. Ensure that no identifying information is revealed, disguising details as needed to protect the confidentiality of the survivor/Victim .

Respect

- Do not ask inappropriate questions like—are you a virgin?
- All survivor/Victim s have different ways of coping, and we need to be considerate of them.
- All actions taken will be guided by respect for the choices, wishes, rights, and dignity of the victim/survivor. Some examples:
  - Conduct interviews and examinations in private settings and with same sex translators, wherever possible.
  - Always try to conduct interviews and examinations with staff of the same sex as the victim/survivor/Victim (e.g., woman survivor/Victim /victim to woman interviewer or health worker)
  - Be a good listener.
  - Maintaining a non-judgmental manner.
  - Be patient; do not press for more information if the survivor/Victim /victim is not ready to speak about her experience.
  - Ask survivors/victims only relevant questions.
  - The prior sexual history or status of virginity of the survivor/Victim is not an issue and should not be discussed.
  - Avoid requiring the survivor/Victim to repeat her story in multiple interviews.
  - Do not laugh or show any disrespect for the individual or her culture, family or situation.

Non-discrimination:

- Provide all survivors/victims (married or unmarried, girls, boys and men) with access to services
- Ensure same sex interviewers including interpreter, medical worker, police officer, protection officer, community service worker and other whenever possible.

MODULE 2
THE LAW AND S/GBV AND VAC

DESCRIPTION OF THE MODULE:

This Module introduces health workers to the basic human rights, the law and the legal frame work on Sexual and Gender Based Violence and Violence Against Children (S/GBV & VAC) in Uganda. The module simplifies complex legal information to enable the health workers give advice to individual patients and to address the human rights aspects of their work.

Health workers have the key mandate to respond to GBV and VAC as stipulated in the International and National Legal frame work. Therefore the knowledge acquired will enable health workers to promote and protect the rights of victims/ of GBV and VAC.

Health workers have the responsibility to examine, document correctly and participate in court proceedings.

This module may be modified to suit the level of experience of the participants or local context.

THIS MODULE WILL INCLUDE THE FOLLOWING SESSIONS:

1. Introduction to Law
2. Human rights and Women's rights
3. Children's rights
4. The national legal framework on S/GBV and VAC
5. Relevance of medical evidence in prosecution of S/GBV and VAC cases
6. Abortion and the law

MODULE OBJECTIVES

1. Introduce health workers to the legal framework on S/GBV and VAC.
2. Promote an understanding of the relationship between S/GBV, VAC and the human rights
3. Enable health workers to understand their role in access to justice by properly collecting, documenting and giving evidence in cases of S/GBV and VAC.
4. Equip health workers with legal knowledge for the effective handling of S/GBV and VAC survivors/victims and enable them refer their patients for appropriate legal services available.
5. Build the confidence of health workers to properly collect and document forensic evidence and testify in court.

Session 2.1: Introduction to Law

SESSION OBJECTIVES:

By the end of the session, participants will be able to:

1. Explain the meaning of law and their characteristics
2. Discuss the general functions of law
3. Explain the hierarchy of laws in Uganda
4. Explain the relevance of the law to the medical workers
5. Explain the different forms of law.

WHAT IS LAW

Law is a set of rules or regulations made by government to govern a given society and maintain order by providing a set of norms which people are expected to live by.

Characteristics of the law:

a) Law controls behaviour by laying out what people can do and what they cannot do.
b) Law provides an orderly and peaceful way to resolve disputes, grievances and conflicts in society.
c) Law provides relief to those hurt by actions of other people in society.
d) Law is shaped by the beliefs in a society and varies from society to society. What is legal in one society may be illegal in another.
e) Laws must be written down to provide certainty and predictability of the consequences.
f) Applies equally to all people without fear or favour, whether male or female, rich or poor, pagan or religious, etc.

FUNCTIONS OF LAW

a) Enables people to live in an orderly manner
b) Provides solutions to harm done
c) Guides human conduct and professional ethics
d) Sets out rights and responsibilities.
e) Punishes criminals.
f) Educates others from the past experiences and deter similar occurrences.
g) Supports access to justice

HIERARCHY OF THE LAWS:

CONSTITUTION
This is the highest or supreme law of Uganda. This means that all other laws are below and subject to it. Any provision in these laws that is contrary to the Constitution cannot be enforced.

ACTS / STATUTORY LAWS
These are laws passed by parliament, such as the Penal Code, the Domestic Violence Act, The Prevention of an Trafficking Act, the Medical and Dental Practitioner's Act, The Children Act, The prohibition of Female Genital Mutilation Act etc.

STATUTORY INSTRUMENTS / RULES AND REGULATIONS
These are usually enacted by the line Ministry to operationalise the specific Act. For example; The Domestic Violence Regulations, The Family and Children Court Rules

POLICIES
These are general principles which guide government in the management of its public affairs. For instance; the national policy on elimination of gender based violence, Gender Policy, the National Youth Policy on Gender Based Violence, National Strategic Plan on Violence against Children in Schools

ORDINANCES
These are rules passed by the district local government and only apply to that district. The rules should not be in conflict with any written law.

BYE LAWS
These are rules or administrative provisions adopted by an organization or community, village, parish, sub county for its internal governance;

CUSTOMARY LAWS
These are rules/customs/traditions governing a particular tribe, clan, community. In many instances customary law is unwritten.
The Constitution of Uganda recognises the positive cultures (Art 36). However, any laws, cultures, customs or traditions that are against the dignity, welfare or interests of women, children and other marginalised groups or which undermine their status are prohibited by the Constitution (Art 32 (2) Customary law can only be enforced if it does not contradict the Constitution or Statutes.

GUIDELINES
There is no legal definition but a guideline is generally understood to mean something that gives directions and aims to streamline particular processes according to a set routine. E.g. standard operating procedures, Uganda National Clinical Guidelines (UCG).

Forms of Law:

In Uganda, laws fall between 2 major categories: civil or criminal law.

CIVIL LAW

To whom does civil law apply?

It applies to private individuals. It includes all the laws that regulate the relationship between individuals and other individuals; individuals and the state; individuals and other bodies like companies, organization.

Examples of civil cases include:

- A health worker who has not been paid by a hospital;
- A patient who has suffered injury through the negligence of a health worker
- A survivor/victim who has suffered injury can sue for compensation
- A victim/survivor can also seek protection orders under the Domestic Violence Act (DVA)

What are the aims of civil law?

a) Offer compensation to a person who has suffered any harm or wrong
b) Make good of any damage done to the claimant,
c) Declare who is right and who is wrong
d) Pay back to the survivor/victim what he/she has spent in bringing the case to court (costs).

Who can bring a case under civil law?

The survivors/victim or person injured or affected by the wrong ,parent or guardian or caretaker of victim/survivor is the one who brings a civil case to court. A person who brings a civil case is called the Plaintiff and the person against whom the case is brought is a defendant.

What is the standard of evidence required to prove a civil case?

- The court decides civil cases on the balance of probabilities. This means that the court decides on the basis of determining who is more likely to be right depending on the evidence produced.
- The survivor/victim needs to convince the judge through evidence that one's case is likely to be true (on a balance of slightly above 50%).

Who has the duty to prove that harm has been suffered?

It is the responsibility of the victim/survivor or complainant to bring evidence to support his/her case.

CRIMINAL LAW

Definition of criminal law

- Criminal Law involves breaking the law that is punishable by the state. In this case, the wrong that is committed affects the state.
- A criminal case is brought by the state on behalf of the injured person (victim) against the person suspected of having committed the crime. Examples of crimes include: rape, defilement, assault, trafficking of person, domestic violence.

No person shall be convicted of a criminal offence unless the offence is defined and the penalty for it prescribed by law (Art.28(12).

What are the aims of criminal law?

a) To Protect Society from harm
b) Punish the offender.
c) To regulate society
d) To deter others from committing similar acts

To whom does criminal law apply?

Every suspected person can be charged with a criminal offence.

Who can bring a case under criminal law?

- Victims/survivors, local leaders, medical personnel and people in authority can report criminal cases.
- It is the duty of the state to investigate crimes once reported and to bring the offender to court.
- The police investigate the crime committed and forward the file to the Directorate of Public Prosecution (DPP) to prosecute the case in the courts of law.
- The state is represented by the prosecutor also known as the state attorney who brings the case before court.

However, an individual can prosecute a criminal case in the courts of law where the DPP consents.

What is the standard of evidence required to prove a criminal case?

- A criminal case is decided ***beyond reasonable doubt***.
- This means that the court must be satisfied that there is no doubt that the person accused is the one who committed the offence. In other words, the evidence must be almost equal to100% that a crime was committed.
- If the evidence is not consistent, is unclear or insufficient, the accused person is set free. The aim is to avoid punishing people who may be innocent.

Who has the duty to prove that harm has been suffered?

- The state through the police and DPP have the burden of proving the case
- The suspect is not required to say anything to defend him/herself. For instance, he or she may choose to remain quiet during the whole trial while the prosecution brings evidence to convince court that the suspect is the one who committed the offence.

How does the State prove the case?

- Through ordinary witnesses e.g. victims/survivors, persons who witnessed the crime and police officers who conduct investigations, visit scenes of crime, recover exhibits and conduct arrests and searches.
- Expert / professional witnesses e.g. health workers, ballistic experts, government analysts, pathologists, etc.
- Local leaders who receive complaints, visit scenes of the crime and conduct arrests.

DIFFERENCES BETWEEN CRIMINAL AND CIVIL LAW

	CRIMINAL LAW	CIVIL LAW
PURPOSE	▪ Protect people and society ▪ Punish criminals ▪ Stop an illegal activity	▪ Settle problems between parties ▪ Pay a victim for the injury to the person or damage to property
THE PARTIES	▪ The accused and the state; for example Uganda Versus Kiwojjolo (accused)	▪ Plaintiff and defendant ▪ Gonja (plaintiff) Versus Muwogo (defendant)
NATURE OF PUNISHMENT	▪ Imprisonment ▪ Fine ▪ Probation, ▪ Community service	▪ Repair or replace damaged property ▪ Compensation to victim ▪ Orders not to act in the same way again

LEARNING POINTS

- Law is a set of rules and regulations governing society
- The Constitution is the supreme law of the land.
- Customary law can only be enforced if it does not contradict what is in the Statute or Constitution of Uganda.

Session 2.2: Human Rights

SESSION OBJECTIVES:

By the end of the session, participants will be able to:

1. Define human rights
2. Discuss the concepts of human rights
3. 3. Discuss the key international, regional and national human rights instruments relating to S/GBV and VAC.
4. Explain the relationship between rights and the law

DEFINITION OF HUMAN RIGHTS:

A human right is an individual's entitlement in society by virtue of being a human being irrespective or regardless of sex, race, colour, language, national origin, age, class, ethnicity, qualifications, and possessions, religious or political beliefs.

CONCEPTS OF HUMAN RIGHTS

Human rights cannot be taken away from a person because one is born with them.

Human rights differ from moral rights which are good but unenforceable in law e.g. a beggar receiving alms may be seen as a moral rather than a legal right.

Human rights are universal and internationally guaranteed and are incorporated in international law and treaties. For example, the Universal Declaration of Human Rights (UDHR), the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC).

Human rights are not absolute but need to be balanced between the rights of the individual in society and the right of the society to govern the individual.

Human rights are inherent, however, these rights are untimely abused in some groups of people like women and children.

KEY INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS RELATING TO S/GBV:

Universal Declaration of Human Rights (UDHR), 1948. ***(From Human Rights Education Associates)***

Article 1. Everyone is free and we should all be treated in the same way.

Article 2. Everyone is equal despite differences in skin colour, sex, religion,

language for example.

Article 3. Everyone has the right to life and to live in freedom and safety.

Article 4. No one has the right to treat you as a slave nor should you make anyone your slave.

Article 5. No one has the right to hurt you or to torture you.

Article 6. Everyone has the right to be treated equally by the law.

Article 7. The law is the same for everyone, it should be applied in the same way to all.

Article 8. Everyone has the right to ask for legal help when their rights are not respected.

Article 9. No one has the right to imprison you unjustly or expel you from your own country.

Article 10. Everyone has the right to a fair and public trial.

Article 11. Everyone should be considered innocent until guilt is proved.

Article 12. Everyone has the right to ask for help if someone tries to harm you, but no-one can enter your home, open your letters or bother you or your family without a good reason.

Article 13. Everyone has the right to travel as they wish.

Article 14. Everyone has the right to go to another country and ask for protection if they are being persecuted or are in danger of being persecuted.

Article 15. Everyone has the right to belong to a country. No one has the right to prevent you from belonging to another country if you wish to.

Article 16. Everyone has the right to marry and have a family.

Article 17. Everyone has the right to own property and possessions.

Article 18. Everyone has the right to practise and observe all aspects of their own religion and change their religion if they want to.

Article 19. Everyone has the right to say what they think and to give and receive information.

Article 20. Everyone has the right to take part in meetings and to join associations in a peaceful way.

Article 21. Everyone has the right to help choose and take part in the government of their country.

Article 22. Everyone has the right to social security and to opportunities to develop their skills.

Article 23. Everyone has the right to work for a fair wage in a safe environment and to join a trade union.

Article 24. Everyone has the right to rest and leisure.

Article 25. Everyone has the right to an adequate standard of living and medical help if they are ill.

Article 26. Everyone has the right to go to school.

Article 27. Everyone has the right to share in their community's cultural life.

Article 28. Everyone must respect the 'social order' that is necessary for all these rights to be available.

Article 29. Everyone must respect the rights of others, the community and public property.

Article 30. No one has the right to take away any of the rights in this declaration.

OTHER KEY INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS RELATING TO S/GBV/ VAC:

- Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), 1979.
- Convention on the Rights of a Child

Declaration on the Elimination of Violence Against Women (DEVAW). The UN Declaration on the Elimination of Violence Against Women (DEVAW) states that violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women. It highlights the different sites of violence against women: violence in the family, violence in the community and violence perpetrated or condoned by the State. The Declaration is sensitive to the fact that particular groups of women are especially prone to be targeted for violence, including minority, indigenous and refugee women, destitute women, women in institutions or in detention, girls, women with disabilities, older women and women in situations of armed conflict. The Declaration sets out a series of measures to be taken by States to prevent and eliminate such violence. It requires States to condemn violence against women and not invoke custom, tradition or religion to avoid their obligations to eliminate such violence. The Beijing Declaration and Platform for Action, adopted by 189 countries at the Fourth World Conference on Women in Beijing in 1995, consolidated these gains by underlining that violence against women is both a violation of women's human rights and an impediment to the full enjoyment by women of all human rights.

- The African Charter on Human and Peoples Rights, 1981.
- The Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (Maputo Protocol), 2003.
- The African Charter on the Rights and Welfare of a Child (ACWRC)
- International Conference on the Great Lakes Region Protocol on the Prevention and Suppression of Sexual, 2006.
- The Goma Declaration on Eradicating Sexual Violence and Ending Impunity in the Great Lakes Region, 2008.

Uganda is a signatory to international and regional instrument on S/GBV and VAC which include the UDHR 1948, ICCPR, Convention Against Torture and other Cruel

Inhuman or Degrading Treatment or Punishment; CEDAW, Beijing Declaration and Platform of Action, 1995, Convention on the Rights of Child, ACRWC, Rome Statute. S/GBV and VAC is also governed by Regional Guidelines among others.. The protocol to the African Charter on Human and People's Rights on the Rights of women in Africa, 2003 (Maputo Protocol), The Great Lakes Protocol on the Prevention and Suppression of Sexual Violence Against Women and Children of 2009 (the Sexual Violence Protocol) expands the scope of international concern around sexual violence and crimes. It also contains a comprehensive set of measures for tackling sexual violence in the region from prosecution to compensation, and expands the range of acts which can form the subject of criminal penalty in international and national law.

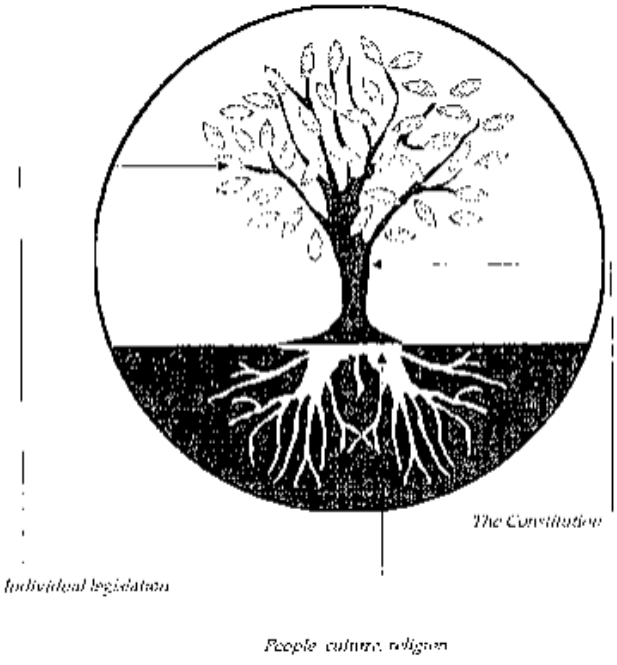
Art.1(5) of the Sexual Violence Protocol encompasses; —…any acts of gender based violence such as rape, forced pregnancy, sexual slavery violate the sexual autonomy and bodily integrity of women and children under international criminal law.

The Prevention and Eradication of Violence Against Women and Children (Addendum to the SADC Declaration of Gender and Development), Art. 3 there in recognizes that violence against women and children includes physical, sexual violence, economic, psychological and emotional abuse.

In Uganda, women and Children's rights are well articulated under the 1995 constitution. The constitution under the bill of rights is considered one of the most progressive on women and Children's rights in the world.

THE RELATIONSHIP BETWEEN RIGHTS AND LAW

Fig 4. Tree of Rights and the Constitution



The roots, which are the source of life and support for the tree [legal system] represent the people, culture, religion, etc. which contribute to the values in society.

The tree trunk, which is the main support and channel for nutrients represents the Constitution. The Constitution is the principal source of law in the country. The Constitution contains a Bill of the rights.

The branches represent the individual legislation e.g. the Medical and Dental Practitioners Act, the Mental Health Act, the Penal Code Act, The Domestic Relations Act etc. Each of these has its validity in the Constitution. The Constitution itself is rooted in the values of the people of Uganda.

2.2.1 WOMEN'S RIGHTS

Session objectives:

1. Discuss the women's rights under the 1995 constitution.
2. Outline important Sexual and reproductive Health rights in relation to S/GBV.
3. Discuss the examples of GBV and the rights violated.
4. Discuss the social context of violence in Uganda
5. Discuss the role of the State in upholding human rights in respect to S/GBV and VAC.

Introduction

***HARD FACTS* STATISTICS OF S/GBV IN UGANDA**

39% of women in Uganda have ever experienced sexual violence (MGLSD2008:14)

59.6% of women have ever experienced physical violence. (MGLSD2008:17).

50.4% of physical violence against women in Uganda is committed by their current husbands/partners (MGLSD 2008:14)

92% stated that DV occurs in their LRC, communities, (2007:14) Only 11% of men are Victims of DV: (LRC, 2007:15),

Medical officers reported that 48% of perpetrators are men. (LRC, 2007:15-16);

39% of women have ever experienced sexual violence, compared to 11% for men. (MGLSD2008:17)

60% of married women of all ages experience spousal violence (MGLSD2008:21)

Women's rights are the rights and entitlements claimed for women and girls of many societies worldwide. In some places, these rights are institutionalized or supported by law, local custom, and behaviour, whereas in others they may be ignored or suppressed. They differ from broader notions of human rights through claims of an inherent historical and traditional bias against the exercise of rights by women and girls, in favour of men and boys.

Violence against women is influenced by social attitudes and values which see men as naturally superior to women and make it a man's right and responsibility to control women's behaviour. Acceptable behaviour

is determined by the man and the failure of women to live within these defined restrictions may result in violence;

Although culture and the social practices often come up in discussions about SGBV, culture should never be used to suppress or harm another individual.

Issues commonly associated with notions of women's rights include, though are not limited to, the right: to bodily integrity and autonomy; to vote; to hold public office; to work; to birth control; to have an abortion; to be free from rape; to fair wages or equal pay; to own property; to education; to serve in the military or be conscripted; to enter into legal contracts; and to have marital or parental rights.

See some of the rights in the Constitution highlighted below;

Women's rights under the1995 Constitution

Article 21 provides for equal treatment in all spheres of life under the law regardless of sex.

Article 26(1) protects all persons from deprivation of property

Articles 31(1) entitles women and men to equal rights during and after marriage

Article 32(1) mandates the state to take affirmative action in favour of groups marginalized on the basis of gender or any other reason created by history, tradition or custom.

Article 33 (4) further avers that the state shall provide facilities and opportunities necessary to enhance the welfare of women to enable them realize their full potential and advancement.

33(5) accords affirmative action to women for purposes of redressing the imbalances created by history, tradition or custom in political offices

33(6) prohibits—laws, cultures and traditions, which are against the dignity, welfare or interest of women and undermine their status.

The Constitutional so mandates parliament, among other things, to make laws for the establishing of an Equal Opportunities Commission (EOC) for the purpose of giving effect to constitutional mandates expressed therein.

What is Violence against Women

Violence against women (VAW) are collectively violent acts that are primarily or exclusively committed against women and girls because they are female. The UN Declaration on the Elimination of Violence Against Women states, "violence against women is a manifestation of historically unequal power relations between men and women" and "violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men".

Kofi Annan, Secretary-General of the United Nations, declared in a 2006 report posted on the United Nations Development Fund for Women (UNIFEM):

> *"Violence against women and girls is a problem of pandemic proportions. At least one out of every three women around the world has been beaten, coerced into sex, or otherwise abused in her lifetime with the abuser usually someone known to her"*

WHY WOMEN'S RIGHT

- Lack of previous application of human rights norms to women.
- Injustices in private sphere were ignored and even condoned.
- Violations of women's rights on grounds of culture/customary laws, tradition and religion.
- Language used in other human rights instruments was male specific.
- Conventions were dependent on happenings in the public sphere which mainly included experiences of men. Most of what happened to women was in the private.

Important Sexual rights and reproductive Health rights in relation to S/GBV

a) Sexual rights

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus documents. They include the right of all persons, free of coercion, discrimination, and violence:

- To the highest attainable standard of sexual health, and access to sexual and reproductive health care services;
- To seek, receive and impart information related to sexuality;
- To sexuality education;
- To respect for bodily integrity;
- To choose their partner;
- To decide to be sexually active or not;
- To consensual marriage;
- To decide whether or not, and when to have children; and
- To pursue a satisfying, safe and pleasurable sexual life.

b) Reproductive health rights

These rights can be used to protect and promote gender equality in reproductive and sexual health. Reproductive Rights include:

(i) **The right to life:** traditionally understood to relate to freedom from arbitrary deprivation of life but also includes the active prevention of death by the State like prevention of maternal and neonatal deaths. Think about 600,000 women who die every year from avoidable causes.

(ii) **Rights to bodily integrity and security of person:** relates to actions concerning individuals in custody of the state. Now also includes understanding this right

as including security from sexual violence and assault at the hands of a partner or others. As well as in relation to population programmes that compel sterilization or abortion, or those that physically prohibit women from receiving family planning.

(iii) **The right to seek, receive and impart information:** traditionally understood only in relation with media and a free press but now also applies in relation to access and utilize reproductive health information to enable women make informed choices in use of contraceptives, seeking legal redress following S/GBV, need for continued counselling and support.

(iv) **The right to health:** traditionally understood to refer to the right of individuals to the highest attainable standard of physical and mental health. It includes access to occupational therapy and rehabilitation services,

Interventions targeting women have been designed to enable women enjoy their right to health for example there is increased funding for availability, accessibility, affordability and quality of maternal health services.

(v) **The right to equality in marriage and divorce:** Traditionally understood to refer to the equal ability of women and men to voluntarily enter a marriage and divorce. The right has often been neglected or violated because unequal treatment of the parties in marriage is tolerated, acknowledged or even condoned by governments. Every person is equal before, at celebration, during the marriage and at dissolution.

(vi) **Right to protection from inhuman and degrading treatment**

EXAMPLES OF GBV AND THE RIGHTS THEY VIOLATE

Violation	Rights Affected and their basis in the Constitution
Rape	The right of personal dignity and integrity (Art 24) The right to choose The right to security of person The right to health (Art 33-3, 34, 35) The Right to life
Domestic Violence	The right to security of person The right to health(Art33-3,34,35) The right to protection from in human and degrading treatment (Art24) The right of personal dignity and integrity Freedom from slavery and servitude Freedom from forced labour
Sexual Exploitation and Abuse	The right of personal dignity and integrity The right to security of person

Violation	Rights Affected and their basis in the Constitution
	The right to privacy
Early and forced marriages	The right to choose e.g right to consensual marriage The right to bodily integrity The right to privacy (Art 27) The right to health(Art33-3,34.35)
Forced pregnancies/ unwanted pregnancies	The right to choose The right to personal dignity and integrity The right to liberty (Art23) The right to life
Infection with HIV	The right to life(Art22) The right to access to information and health care The right to choose and take decisions about one's self
Self	The right to liberty (Art23) The right to access to information (informed choice)
Female Genital Mutilation	The right to choose The right to bodily integrity The right to privacy The right to health (Art33-3,34,35) Right to life

Role of the State in upholding human rights in respect to S/GBV and VAC

The Human rights system creates three major obligations on the government. These include the obligations to: respect; protect and fulfil. It should be noted that government works through its agents including health professionals who are also required to observe these obligations in performing their duties.

Fundamental rights and freedoms of the individual are inherent and not granted by the State. The rights and freedoms of the individual and groups enshrined in the constitution shall be respected, upheld and promoted by all organs and agencies of Government and by all persons. (Art. 20)

The State has an obligation to respect human rights. This means that the government and its agencies should refrain from interfering with the enjoyment of rights. States have the obligation to work to ensure that no government practices, policies, programs, or legal measures violates human right, ensuring provision of services to all the population groups on the basis of equality and freedom from discrimination, paying particular attention to the vulnerable and marginalized groups.

The State has an obligation to protect rights by preventing third parties from interfering with the enjoyment of the rights. For example, this obligation calls upon government to prevent pharmaceutical companies and health insurance providers from infringing human right. See: Case study one:

Case Study One:

In 1996, the Social and Economic Rights Action Centre (SERAC) brought a case against Nigeria to the African Commission on Human and Peoples' Rights alleging that the military government had, through its business relationship with Shell Petroleum Development Corporation (SPDC), exploited oil reserves in Ogoni land with no regard for the health or environment of the Ogoni People. This exploitation had resulted in extensive pollution of the local habitat, seriously affecting the food production of the area. It had also resulted in serious short and long-term health consequences for the Ogoni, yet no safeguards or additional provisions for healthcare had been made. Furthermore, a second claim alleged that the Nigerian state used its armed forces to effect violent reprisals against Ogoni protestors challenging the oil company's practices. According to the African Commission on Human and Peoples' Rights: Nigeria's failure to prevent Shell from polluting environment was a breach of their duty to protect the rights to food and to health environment of Ogoni people

The State has an obligation to fulfil which requires the government to adopt appropriate measures towards full realizations of the rights such as appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of human right. This includes the obligation to provide some sort of redress that people know about and can access if they feel that their health related rights have been infringed by the state or non-state actor. The State must take all measures (legislative, administrative, social, and educational) taken to prevent and respond to violence, exploitation, neglect, and abuse against children (including commercial sexual exploitation, trafficking, child labor, and harmful traditional practices, such as female genital mutilation/cutting and child marriage).

Case Study Two:

In Grootbroom v South Africa- Poor homeless people evicted from informal homes situated on private land earmarked for formal low-cost housing in South Africa applied to Court for an order requiring government to provide them with adequate basic shelter or housing until they obtained permanent accommodation. The constitutional court ruled that the State was obliged to take positive action to meet the needs of those living in extreme conditions of poverty, homelessness or intolerable housing.

Health workers as agents of the State have an obligation to respect, promote and fulfilling the rights by;

- Implementing laws and policies that prohibit GBV and VAC
- By observing the Professional ethics and the Patient's Charter

LEARNING POINTS

- Human Rights: Human rights are those rights that every human being possesses and is entitled to enjoy simply by the virtue of being human. All acts of sexual and gender based violence are violations of fundamental human rights.
- The disrespect of human rights is among the root causes of sexual violence.
- Legal Rights are recognized and enforceable by law.
- The difference between human rights and the law is that human rights are universal while law is specific to a given country and can be made for a specific group;
- Legal rights in respect of patients include the right to medical care, information, treatment, etc
- Women rights are human rights.

Session 2.2.2: Children's Rights

SESSION OBJECTIVES:

By the end of the session, participants will be able to:

1. Define a child
2. Discuss Children's Rights and the laws governing them.
3. Explain the categories of children's rights
4. Discuss forms of Violence Against Children (VAC).

WHO IS A CHILD?

Under the 1995 Constitution as amended and Children Act , a child is a person below the age of 18 years..

Rights of the child:

Rights are things every child should have or be able to do. All children have the same rights. These rights are listed in the UN Convention on the Rights of the Child. Almost every country has agreed to these rights. All the rights are connected to each other, and all are equally important.

They are for the best interest of a child in a given situation, what is critical to life and protection from harm. Children have rights, responsibilities and as they grow they can participate in decision making in matters that affect the enjoyment of their rights.

The rights include:

- Right to good nutrition
- Right to life (according to the CRC, states must ensure the survival and development of a child)
- Right to education
- Right to safe drinking water
- Right to healthy environment
- Right to participate actively in the promotion of his or her rights
- Right to join associations
- Right to identity
- Right to communicate
- Right to privacy
- Right to recreation and leisure
- Right to freedom from discrimination
- Right to protection against exploitation and inhumane treatment

What are the key laws and policies governing children's rights?

- United Nations Charter on the Rights of the Child, (CRC) 1989;
- The African Charter on the Rights and Welfare of the Child
- The 1995 Constitution of the Republic of Uganda as amended.
- Children Act, Cap 59 as amended.
- The Domestic Violence Act
- The Prevention of Trafficking in persons Act
- The Prohibition of Female Genital Mutilation ACT
- Penal Code Act
- The Employment Act
- The Employment (Employment of Children) Regulations No.11 of 2012

Who is responsible for the child rights?

Section 5 (1) the Children Act, Cap 59 as amended and the National Population Policy impose a duty on the parents, guardians or custodian to maintain a child and provide their basic needs.

A child who is capable of forming his or her own views has a right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child (Article 12 CRC).

Every child has a right to be protected against all forms of violence including sexual abuse and exploitation, child sacrifice, child labor, child marriage, child trafficking, institutional abuse, female genital mutilation and any other forms of abuse. It further states that anyone who further believes that a child is being abused, neglected or under imminent danger of being abused or injured may report the matter to the designated authority. Reporting is mandatory for medical practitioners, social workers teachers and community members with regard to children under their care(S.42A Children (Amendment) Act.

What are the rights of special groups of children?

These include children with disabilities mental and physical, children with chronic diseases like sickle cells, children with HIV, Children with mental illnesses and a girl child.

Such a child in the special groups has equal opportunities for education, right equality and non-discrimination on grounds and right to health (A right of access to medical care)

What are the categories of children's rights?

Survival	The right to life and give the needs that are most basics to life. Such as, shelter, nutrition and access to medical services.
Development	Right that covers the things that help children to reach their full potential. Such as, education, play and leisure, cultural activities, access to information, freedom of thoughts, conscience and religion.
Protection	Rights that require children to be safe guarded against abuse, neglect and exploitation. Such as, special care for refugee children, protection against torture, abuses in the criminal justice system, involvement in armed conflict, child labour, drug abuse, and sexual protection.
Participation	Rights that allow children to take an active role in their communities and country. Such as freedom to express opinions, to have a say in matters affecting their own lives, to join association, to assemble peacefully, to participate in the activities of their society and in the protection of their rights;

Responsibilities: Children's rights are a special case because many of the rights laid down in the Convention on the Rights of the Child have to be provided by adults or the state. However, the African Charter on the Rights and Welfare of a Child refers to the responsibilities of children, in particular Children have responsibilities towards their families and societies, to respect their parents, superiors and elders, to preserve and strengthen African cultural values in their relation with other members of their communities (Article 31).

SUMMARY OF RIGHTS AND RESPONSIBILITIES

Right	Responsibilities
Enjoyment of human rights	Respect and promotion of rights of others:
Equal treatment and not to be subjected to any form of discrimination on the basis of his/her religion, sex, nationality, colour or race.	Learn about people of other nationalities, religions, sex, colour and races in order to appreciate diversity and the need to live in harmony with everyone; with guidance and proper instruction has to be proud of his/her religion, sex, nationality, colour and race.
Live with his/her parents or guardians, be loved, cared for and protected from abuse or neglect;	Obedience, discipline and ability to listen, seek guidance from parents/guardians, learn the values of love, harmonious loving, happiness and understanding in the home where he/she stays.
Basic education for all.	Attendance at school, willingness to learn, doing exercises and obeying school rules.

Right	Responsibilities
Recreation and play	Participate in extra-curricular activities at school such as being a member of a dance group, choir or club. Use his/her leisure time properly and creatively.
Good and healthy diet, clothing, housing and medical care including early assessment of children with disabilities and appropriate treatment.	Eat the food given, sleep and take the medicine for treatment.
Clean and secure environment, live with parents/guardians, be loved and protected from abuse.	Keeping self and environment clean.
Protection from social and customary practices harmful to health, education, mental, physical, or moral development.	Participate in those activities appropriate for his/her age in order to develop life skills
Equal treatment and non-discrimination on basis of religion, sex, nationality, colour or race.	Respect for other people's religion, sex, nationality, colour or race.

Forms of Violence against Children

Violence Against Children is a broad term that is used to include deliberate behavior by people against children that is likely to cause physical or psychological harm.

Violence means any form of physical, emotional or mental injury or abuse, neglect, maltreatment and exploitation, including sexual abuse, intentional use of physical force or power, threatened or actual, against an individual which may result in or has a high likelihood of resulting injury, death, psychological harm, mal-development or deprivation (Section 2 Children (Amendment) Act, 2016).

Examples of VAC; child neglect, child sexual abuse, forced prostitution, defilement, incest, harmful traditional practices like FGM, child trafficking, child pornography, child labour etc.

According to Article 19 of the UN Convention on the Rights of the Child, "violence" is understood to mean "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, exploitation or maltreatment, including sexual abuse."

EXAMPLES OF VAC AND THE RIGHTS THEY VIOLATE

Violation	Rights Affected and their basis in the Constitution
Defilement and attempted defilement, indecent assault, incest	The right of personal dignity and integrity (Art 24) The right to security of person The right to health (Art 33-3, 34, 35) The Right to life
Domestic Violence	The right to security of person The right to health (Art33 (3), 34, 35) The right to protection from in human and degrading treatment (Art24) The right of personal dignity and integrity Freedom from slavery and servitude Freedom from forced labour
Sexual Exploitation and Abuse	The right of personal dignity and integrity Right to education Right to health The right to security of person The right to privacy
Harmful traditional practices like Child marriages, Female Genital mutilation	The right to bodily integrity The right to privacy (Art 27) The right to health (Art33 (3), 34, 35) Right to education Right to survival and development
Forced pregnancies/unwanted pregnancies	The right to personal dignity and integrity The right to liberty (Art23) The right to life Right to education Right to survival and development
Infection with HIV	The right to life (Art22) The right to access to information and health care The right to choose and take decisions about one's self
Child trafficking	Right to life Right to education Right to be cared for by their parents Right to health Right to liberty and safety Freedom from cruel, inhuman and degrading treatment
Child pornography	Right to life, survival & development Right to health

Violation	Rights Affected and their basis in the Constitution
	Right to education Right to safety and privacy
Prostitution	Right to life Right to health Right to education Freedom from slavery & servitude Right to bodily integrity Freedom from cruel, inhumane and degrading treatment
Child Labour, child neglect and abuse,	Right to education Freedom from slavery & servitude Right to bodily integrity Freedom from cruel, inhumane and degrading treatment Right to life Right to health

Session 2.4: The Relevance of Medical Evidence in Prosecution of S/GBV and VAC Cases

SESSION OBJECTIVES:

By the end of the session, participants will be able to:

1. Define evidence and its importance
2. Discuss the different types of relevant evidence which can be produced in court
3. Explain the importance of medical evidence in S/GBV and VAC
4. Explain reasons for proper collection and documentation of evidence in S/GBV and VAC cases
5. Discuss the procedure for producing medical evidence in court

WHAT IS EVIDENCE?

Evidence is:

- The means by which any alleged dispute is proved or disproved before a court of law.
- Simply put evidence is any information that helps establish the truth before a court of law.

What are the forms/types of evidence and examples?

a) **Oral:** Statements made by a witness in a court of law.

b) **Direct evidence**: testimony of a witness who perceived any situation using any of the five senses

c) **Hearsay:** evidence given by a person who did not directly witnesses a crime such as see or hear

d) **Documentary evidence:** All documents produced for the inspection of court. These include: medical reports, Photographs, scans x-rays, laboratory test, documents,

e) **Physical objects (exhibits):** clothing, shoes, swabs from wounds and vagina, anus and mouth, tests, medical report

KEY CONCEPTS OF EVIDENCE.

Document: Any matter expressed or described by means of letters, figures or marks.

Documentary evidence: All documents produced for the inspection of court.

Fact: Anything, state of things, or relation of things

Fact in issue: Any fact is asserted, denied or sought to be proved in any case.

Oral evidence: Statements made by a witness in a court of law.

Hearsay: evidence given by a person who did not directly witnesses a crime such as see or hear.

Conviction: where the suspect or accused person, is found guilty of the offence

Burden of Proof: refers to who has the duty to prove a certain fact before the court. It is upon that person who wants the court to believe his/her evidence who should produce that evidence in court.

Who may give evidence (testify) in court?

- All persons who are in the opinion of court and are able to understand the questions that may be put to them, and are not barred/restricted from testifying by the law.
- A dumb person may give evidence using sign language or in writing.
- A blind person may give oral evidence about what they have heard and the smell.
- A public officer can give evidence in respect to matters that come to him/her in the course of his/her duties except if it is against public interest.
- A lawyer may not disclose information given to him/her about the client in confidence.

Can a married couple give evidence against each other?

- In criminal cases a spouse (a legally married person) is a competent but not compellable witness against his/her spouse, except with the consent of the other spouse. This means that while a husband or wife cannot be forced to testify against each other in criminal cases for the prosecution, they may give evidence to support the accused spouse.
- The above does not apply to Civil cases.

Why is medical evidence important for S/GBV and VAC?

- S/GBV and VAC cases are criminal in nature and must be proved ***beyond reasonable doubt***. Independent evidence like medical evidence is usually required to corroborate and confirm the evidence provided by the victim
- regarding the act constituting the offence having taken place or connecting the suspect/accused to the offence or exonerating.
- The evidence of health workers as expert witnesses enables the court to prove the injuries suffered by the victim and to connect the suspect to the crime. Therefore it is a good practice to examine both victim and suspect within the same period.
- It's required in estimating the age of the client especially children.
- It's used by court to determine the nature and magnitude of the offence i.e. in the case of defilement, the HIV status of the perpetrator is required for classification of defilement by the law. It's used to help identify the perpetrators for example through DNA.
- It's needed to establish and classify the magnitude of harm/damage in physical, sexual and psychological S/GBV and VAC e.g. grievous harm, dangerous harm and maim etc.

  In summary, medical evidence is a means and gateway to justice.

Why is it important to collect and document medical evidence promptly?

- Often times evidence is lost/destroyed out of delay in collecting it e.g. a woman or child has bathed or changed clothing

- Evidence may be washed away in the daily hygiene routine e.g. washing bed sheets.
- The scene of crime can still be found intact.

Reasons for proper collection and documentation of evidence in S/GBV and VAC cases

The role of the medical worker as an ***expert witness*** is to assist the court to establish the truth by providing technical guidance on matters within the medical/health profession. In S/GBV and VAC cases, the role of the health worker is to establish whether the violence occurred and whether there is a connection between the victim and the suspect and report his/her findings on the police form provided for that purpose.

Victims of S/GBV and VAC are vulnerable witnesses because of trauma, stigma, age, psychological and psychosocial effects of the offence and therefore need to be handled carefully throughout the legal process including medical examination.

Good Practices

It is good to always observe the following:

- In the case of victims the examination should involve a physical examination of the entire body with a view to determine which parts of the body were affected, how and the extent of the injury.
- Examination of both the victim and suspect should be done with the nature/circumstances of the offence in mind, for guidance.
- The nature of injuries/symptoms on the bodies of the victim and the suspect should be clearly recorded because they are relevant.
- In sexual offences other evidence of sexual contact apart from vaginal penetration, should be recorded.
- In defilement cases evidence of a sexual act, other than penetration should be looked for.
- The nature of injuries suffered are sometimes relevant in cases where lack of consent is an issue.
- The emotional state of the victim should also be examined and reported on.
- Referral should be done and recorded
- The examination should be done with the type, time of offence in mind, to determine the relevance of the injuries/symptoms to the facts.
- Immediate examination of the victim and suspect to determine recent contact or sexual activity yields the best results, including matching injuries and identification of body fluids.
- The estimated age of the victim or accused must be examined and stated clearly, not by just saying he/she is below or above a certain age but with scientific justification.

- The time of examination and the conclusion as to the time the offence took place are critical and must be determined to the stability of the medical/health practitioner, to establish consistency with the facts of the case.
- The medical/health practitioner should be able to comment on any relevant matters or findings which he/she feels could be of use to court, even where the police form does not seek for such answers.
- Notes/remarks are very useful to court and to yourself at the time of your testimony.
- Whenever technical terms are used try to explain them in simple English which police, prosecution and court understands.
- The report should be readable
- Avoid use of legal terms in your findings e.g. defilement, rape, indecent assault as they might carry a different meaning from what you think.
- Give your conclusions basing on your findings
- The prosecutor must understand and appreciate the findings of the expert before using them in court.
- In case of need for further explanation, request to make a police statement
- When writing the medical report, take reasonable steps to verify the information and do not leave out relevant information.
- Always sign the medical report
- Use simple and plain English: Medical advice and evidence is usually sought by people who do not come from a medical background. Therefore explain any abbreviations and medical terminology or other technical terminology used.
- Be honest and trustworthy: Do not exaggerate or mislead the court about experience, qualifications, working position or injuries of the victim.
- When giving evidence or writing the medical report, restrict statement to areas in which you have relevant knowledge or direct experience.

How to conduct yourself in court as an expert witness.

- Cultivate a calm, professional and confident manner by giving all questions proper consideration, then answer with authority. In other words, ensure to understand the question before answering. If the instructions are unclear or conflicting, refrain from answering and let the court know that you do not understand the question and seek clarification from the person asking the question.
- Only address matters that fall within the limits of your professional training, skills or experience. If a particular question or issue falls outside your area of expertise, make it clear to the court. If the court insists that the question be answered, regardless of your expertise, answer to the best of your ability but clarify that such a question is beyond your competence or that you do not have sufficient information to reach an informed conclusion on a particular point.
- Keep up to date in your specialist area of practice.
- Stick to the questions of medical evidence without giving personal opinions.

- Be an independent and an objective witness who is not biased by a personal relationship with the victim or the prosecutor.
- Do not allow personal views about any individual's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, social or economic issue bias or influence the expert opinion.
- Conflicts of interest: Any potential conflict of interest, such as any prior involvement with one of the parties, or a personal interest, must be disclosed to the court so that the court decides whether or not to give the expert evidence.
- Give a balanced opinion: State the facts or assumptions on which the opinion is based. If there is a range of opinions on the question asked, explain your position.
- Study the medical report before going to the witness box and avoid reading it in the court to refresh memory. Take minimal materials into the witness box and do not unnecessarily refer to any document without first seeking permission of the judge.
- It is advisable that when you fill in a PF3 form, keep an original copy for yourself.
- Ensure that you understand, and adhere to, the medical code of practice that affects your work as an expert witness. For example, respect the client's confidentiality.
- Do not disclose confidential information except where:
  (i) the person consents to it preferably in writing;
  (ii) are obliged to do so by law
  (iii) are ordered to do so by a court or tribunal.
- When asked to give advice or opinion about an individual without the opportunity to consult with or examine them, explain any limitations that this may place on your advice or opinion.

Procedure for producing medical evidence in court:

Witness summons

When you receive witness summons:

- Ask which room/office you are required to report to, and any other clarifications
- Revise your report to refresh your memory before the court date
- It is important to be in touch with the prosecutor before the time of your testimony, for necessary preparations.
- Do not ignore court summons without explanation to the prosecutor/police officer.
- As soon as you get to the court on the day of hearing, get in touch with the prosecutor or police officer and show your summons to them, for appropriate directions.
- Discuss any issues of concern with the prosecutor or police officer

Testifying in Court

Assume court does not know what happened to the victim/accused whom you

examined – you were summoned to help court reach a just decision in the case

- Introduce yourself fully, including your current duty station and all qualifications, relevant training, skills and experience.
- Answer and explain only questions put to you
- Be confident and firm as you testify
- Remain composed throughout your testimony
- Avoid asking questions or giving rude answers to questions
- Refer to your notes/remarks whenever need arises.
- Know the purpose and nature of cross examination and handle it appropriately:- I cross examination, Counsel to the accused has already read the file and knows everything on it.
- Stand your ground against wrong suggestions and conclusions
- Exercise restraint and patience while in the witness box until court discharges you.

Sample questions asked during cross examination in court

- Yes or No questions; these type of questions may put you in a tough position because whatever you are asked to respond to "yes" is most likely something you rather say "No". are you sure she was raped?
- Hypothetical questions: When you do not understand the question asked, simply respond I don't understand the question and request the person asking the question to rephrase.
- Firing questions: It is important for the expert witness to think carefully before responding to such questions.

Frequently asked questions and answers

Should the health worker go to court?

Health workers should only go to court when they receive summons to testify about specific cases they have handled before.

Is evidence about the character of a person relevant?

- Opinions as to the character of a person is not relevant in criminal cases except if:
- It is given in defence to prove that the accused is of good character:
- There are previous convictions,

Is a health worker required to give evidence about the character of the victim?

- Evidence about the character of the victim is not relevant because it is not the victim on trial.
- A health worker is not required to give evidence about the character of the victim, for example previous times she or he suffered from STDs, how well-behaved she is.
- The patient's information to a health worker is confidential.
- It is not the victim on trial.
- However, where the health worker detects the same STD in both the victim and the suspect such evidence links the suspect to the crime and must be reported.

Is an expert witness allowed to refer to documents while in the court?

- A witness may ask for a document in court to refresh his/her memory when being examined.
- An expert may refresh his/her memory by referring to a professional book.
- However, it is advisable that the medical evidence is studied before going to court in order to create an impression of confidence and competence.

Can a document which is not original be accepted in court as evidence?

Only original documents must be provided in court unless if:

- The original copy is in possession of the other party;
- The person against whom it is used consents to it;
- The original copy is destroyed or lost;
- The original is not easily movable;
- The original is a public document under the law;
- A certified copy is allowed to be admitted by court

NOTE: *Given that only original documents are admissible as evidence, it is a good practice, to fill the police forms in duplicates. An original copy given to the police file and the other copy kept by the health worker.*

Must a medical form be signed?

- An unsigned medical form is not admissible in the courts of law
- The signature of a signed document must be proved in court.
- A person may be called to court to prove that the document in question was signed by a person he/she knows very well.
- In the alternative, the court may require a person to write certain words or figures for comparison with those on a document presented to court that she/he is said to have signed.

Are health workers under a duty to report S/GBV?

- The Constitution puts a duty on any citizen to cooperate with the law enforcement agencies (Art17 (1) f). At the same time the law provides for the right to privacy.
- The health workers are duty bound to protect patient confidentiality , under the right to privacy;
- Reproductive Health Guidelines oblige health workers to observe the patient's rights where the patient is an adult.
- Similarly, pharmacists are expected to respect the confidentiality (Pharmacy and Drug Act (Section16-12).

Is there an obligation to report abuse where the patient is a child?

Where the survivor/victim is a child, the health worker and any other responsible person in the community has the obligation to report abuse to the police, parents, guardians, social workers or persons in authority.

The Reproductive Health Guidelines require consent of the legal guardian in order for children to access the following:

- Evacuation for incomplete abortion
- Examination under general anaesthesia
- Any surgical interventions

Are nurses, midwives and clinical officers allowed to collect and give evidence in court?

- If a nurse, midwife or clinical officer is trained to proficiency, he/she can examine and give evidence in court.
- The evidence should always be recorded on a history and examination form or Medical Form 5 and normal clinical form. However examination findings can also be filled on police form on request by police.

Learning Points

- The evidence given must relate to the key ingredients of the offence.
- Where both the defence and the prosecution agree on a medical report during a trial, the practitioner who prepared the report may not be required to testify in court.
- it is important to clearly document evidence and to sign and stamp a on every page of the medical report.

Session 2.5: National Legal Framework on Sexual and Gender Based Violence and Violence against Children

SESSION OBJECTIVES:

By the end of the session, participants will be able to:

1. Explain the national laws relevant to Sexual and Gender Based Violence and Violence against Children
2. Discuss the key ingredients of the crimes in order to properly record evidence.
3. Discuss the role of health workers in enabling victim's access justice in cases of sexual and gender based violence and Violence against Children.

The legal frame work on S/GBV and VAC

1) The 1995 Constitution of the Republic of Uganda as amended,
2) The Penal Code Act 120 as amended,
3) The Domestic Violence Act, 2010
4) The Prevention of Trafficking in Persons Act,
5) The Children's Act Cap 59, as amended in 2016
6) The prevention of Female Genital Mutilation Act
7) The Anti-Pornography Act
8) The Employment Act
9) The Domestic Violence Regulations
10) The Employment (employment of children) Regulations
11) National Child Labour Policy
12) National Action Plan on Child Sacrifice 2009National Strategic Plan on Violence against Children in schools

Offences under the Penal Code Act

RAPE

Although rape is, in theory, punishable as an offence throughout the country, it has always been under reported, and relatively few prosecutions of rape or crimes of sexual violence have taken place. Survivors have been reluctant to report sexual crimes for fear of stigma. Many survivors suffer intimidation and are thus prevented from reporting crimes or from insisting on the prosecution of perpetrators. There is also enormous pressure from communities not to report the case. Many times the victims are sceptical that they would not receive justice.

Is rape a serious offence?

Rape is a serious offence under the laws of Uganda. It is committed against a woman by a man.

What is rape?

Any person who has unlawful carnal knowledge of a woman or girl, without her consent, or with her consent, if the consent is obtained by force or by means of threats or intimidation of any kind or by fear of bodily harm, or by means of false representations as to the nature of the act, or in the case of a married woman, by personating her husband, commits the felony termed rape (section 123 Penal Code Act).

Simply rape is forceful penetration of the vagina however slight without the consent of the girl or woman.

What are the key elements of the offence?

a) Penetration of the vagina however slight by the penis
b) Without the consent of a woman or girl
c) Where the consent is obtained by force
d) Where the consent is obtained by means of threats or intimidation
e) Where consent is obtained by fear of bodily harm or
f) Where consent is obtained by means of false representations as to the nature of the actor
g) In the case of a married woman, by personating her husband.

Can a man rape his wife?

Under the Penal Code Act, marital rape is not recognised as a crime. However, under the Domestic Violence Act of 2009 marital rape is punishable (to be discussed under Domestic Violence. There are instances where marital rape occurs when the party is not interested in having sex for fear of exposure to HIV/AIDs, where the couple is separated, where any of them is ill.

Can a man be raped?

According to the Penal Code Act, only women or girl can be raped. However, a man can be sodomized (offences against the order of nature), sexually harassed and sexual domestic violence under the Domestic Violence Act.

OTHER SEXUAL ASSAULTS

- The law of rape is restricted to the penetration of the vagina by a penis.
- Where any object is inserted into the vagina, anus, mouth or a sexual organ of a woman above 18 years, this offence is generally referred to as offences against the order of nature.

What is the punishment for rape?

The punishment for rape upon conviction is to suffer death.

- In reality no death penalty has ever been given for the offence of rape.
- Most common punishment is short term imprisonment.

What evidence must health workers record for the successful prosecution of rape?

- Evidence of sex such as semen.
- State of mind of the victim e.g. in shock, trauma, in denial
- Evidence of struggle or injuries on the general body is not necessary, but is useful if found. Put differently, although evidence of struggle must be recorded its absence does not mean that no rape was committed.

When is consent not given: When is sex deemed to have been forced?

a) The person is scared that the person who is asking her to have sex will harm her right away when she says no.
b) The person is scared that something bad will happen to someone else whom she is close to.
c) The person is locked up or stopped from leaving a place
d) The person does not know what is happening because she is not fully conscious, is deeply asleep, drunk, drugged that is not fully aware of what is happening.
e) The person is suffering from sickness and is not capable of agreeing to what is happening to her;
f) The person lies about who he/she is.

DEFILEMENT

Is defilement a serious offence?

Defilement is a very serious offence committed by any person (whether man or woman) on a child (boy or girl) below the age of18 years.

What is defilement?

Any person who performs a sexual act with another person who is below the age of eighteen years commits defilement and is on conviction liable to life imprisonment (Section 129).

What are the elements of defilement?

a) Any contact with the sexual organ, mouth or anus of a child below eighteen years
b) Any contact of the sexual organ on any part of a child's body by any object such as a penis, tongue, stick, lips, finger, etc.

c) Consent of the child to sex is not a defence. A child under the age of 18 years cannot legally consent to sexual intercourse. It is also not a defence that the suspect marries the child as a result of the defilement.
d) Child marriages are illegal and constitute a crime (To be discussed under the prevention trafficking in persons 'Act).

Are there different levels of defilement?

There are two levels of defilement: Simple and Aggravated defilement.

When does aggravated defilement occur?

Aggravated defilement occurs where;

a) A child is below14 years.
b) The offender is HIV positive.
c) The offender is a parent, guardian or person in a position of authority, such as relatives, teacher, LC official.
d) The child has a disability.
e) The offender is a serial offender: Has committed the offence before.

What is the necessary evidence to record for defilement?

- Examine the anus, the mouth and the vagina
- Check the HIV status of the offender and the victim
- Determine the age of the victim to determine s/he is under18 years. Age affects the classification of the case: whether it is defilement or rape.

This evidence is not limited to the above.

Does the law punish children who have sex with each other?

- Yes, the law punishes children who are above 12 years and have sex with each other.
- Child to child sex; Where the offender in the case of defilement is a child under the age of twelve years, the matter shall be dealt with as required by the Children Act (Section 129A(1).
- Where defilement is committed by a male child and a female child upon each other when each is not below the age of twelve years of age, each of the offenders shall be dealt as required by the Children Act (Section 129A(2).
- Under such circumstances the objective is to keep the child in remand home so that they can be rehabilitated.

What is the punishment for defilement?

For aggravated defilement the punishment upon conviction is death..

For simple defilement the punishment upon conviction is life imprisonment.

In addition to the custodial sentences the victims of defilement may receive compensation for any physical, sexual and psychological harm caused to the victim by the offender (S.129B): The compensation shall take into account the harm.

Suffered by the victim, the degree of force used by the offender, the expenses incurred, such as medical evidence.

DIFFERENCE BETWEEN RAPE AND DEFILEMENT

	Rape	Defilement
DEFINITION	Penetration of the vagina by a penis	Contact of the vagina, anus or mouth by anything for sexual motive.
PARTIES	By a man against a woman	By any person, whether man or woman against a boy or a girl
HEARING	In open court or in private	In private
REDRESS	Imprisonment	Imprisonment, death penalty and court may provide compensation for victims to cover damages and costs.

ASSAULTS AND BATTERY

Is Assault a serious case

Assault can be both a minor and serious case depending on the injuries suffered: simple, actual or grievous.

Assault causes harm: — **Harm** means any bodily hurt, disease or disorder whether permanent or temporary.

Dangerous harm includes endangering life

Grievous harm: means any harm which amounts to a maim or which permanently injures health or extends to permanent disfigurement to any external or internal organ, membrane or sense;

What are the ingredients of Assault?

The ingredients for assault include;

a) Inflicting unwarranted fear to another person.

b) Causing actual bodily harm to another person.

What are the examples of incidents that may amount to assault?

a) Domestic violence
b) Corporal punishment (Sec1, PCA Amendment Act 2007).

What is the relevant evidence to record by a health worker for successful prosecution?

Any injury on the body of another person that results in fear, or , maim or disease.

Injury may be permanent or temporary.

Incest.

This is where a person has sexual intercourse with another person with whom, to his or her knowledge, any of the following relationships through blood or marital relationships (Section 144(1).

Ingredients of incest

- The victim of incest was to the accused's knowledge, related to him/her
- Sexual intercourse took place; and
- That it was the accused who was involved in the act Sexual intercourse with a person

What is the punishment for incest?

The person upon conviction is liable to imprisonment for seven years or, if the victim is under the age of eighteen years of age, to imprisonment for life.

It is immaterial that sexual intercourse took place with the consent of the other person.

What is the relevant evidence to record by a health worker for successful prosecution?

- Examine the anus, the mouth and the vagina or Evidence of sex such as semen.
- Check for any sexually transmitted diseases, HIV status of the offender and the victim
- Determine the age of the victim to determine s/he is under18 years
- Check for pregnancy
- Confirm DNA

Offences under the Domestic Violence Act

What is domestic violence? (sec.2)

Any act or omission which harms, injures or endangers the health, safety, life, limb or well-being (whether mental or physical) of the victim'.

It includes:

Physical abuse, sexual abuse, emotional abuse, verbal and psychological abuse, harassment, harm, injures or endangering the victim with a view to coercing a **person living in a home to give in to** any unlawful demand for any property or valuable security, threats to a victim or their relative.

TYPES OF VIOLENCE

Economic	Using economic power to deprive another person economic and financial resources which the victim is entitled to: such as depriving household necessities, property or payment of rent, disposal or destroying of one's property or household items; restriction of access to shared household; not allowing a person to work.
Emotional	Verbal or psychological abuse such as a pattern of humiliating conduct, repeated insults, threats, excessive possessiveness and jealousy amounting to deprivation of privacy, liberty, integrity, security, insults in the presence of a minor which amounts to abuse; harassment by inducing fear of harm and annoyance such as repeated stalking, abusive telephone calls, offensive messages.
Physical	Causing bodily harms or endanger life, body, health or development of the victim. Such as beating, kicking, burning, choking, ritual practices.
Sexual	Any conduct of a sexual nature that abuses, humiliates, degrades or violates the dignity of another person. Such as forcing a sexual activity against one's will such as, rape, obscene touching, sexual harassment, grabbing sexual organs, refusing safe sex;

Who can commit the offence of domestic violence?

Any person in a domestic relationship. This includes:

- A married person,
- a family member,
- any person sharing the same home;
- a domestic worker;
- an employer whether or not the abused person and the abuser stay in the same home; any other relationship that the court would define as a domestic relationship.

What is taken into account in a domestic relationship? (sec.3)

- The nature of the relationship
- The amount of time the parties spend/spent together
- The place where the time is ordinarily spent by the victim and perpetrator
- The manner in which the time is spent

What is the punishment for domestic Violence?

Fine or imprisonment of 2 years or both

The court may order compensation to the victim

Is consent to domestic Violence a defence?

No. Consent to domestic violence is not a defence (sec.5)

Does the Domestic Violence Act include marital rape?

Yes, the Act includes marital rape. This is because the definition of violence includes sexual violence in a domestic setting.

What is the relevant evidence for successful prosecution?

- Establishment of injury or harm.
- Establishment of sexual intercourse

Where is domestic violence reported?

To the local council court (sec. 6) or to the Police (sec.7) Any Magistrate court (sec.9)

Which medical worker/practitioner can provide S/GBV and VAC services?

A medical practitioner can provide such services. The law defines a medical practitioner as a dentist, medical doctor and clinical officer (sec.2 of the 1995 constitution)

Offences under The Prevention of Trafficking of Person's Act

What is trafficking? (sec.2)

It is the recruitment, transportation, transfer, keeping or receiving a person by threat, force, coercion, abduction, fraud, deception, abuse of power or receiving benefit to enable a person having control of another consent to the trafficking.

Who commits the offence of trafficking?

Any person involved in executing a trafficking offence commits an offence. This includes any person who: recruits, transports, transfers, keeps or receive another for purposes of exploitation, hires, confines, or maintains another for purposes of exploitation.

What is child trafficking? (sec.3)

Child trafficking includes the recruitment, transportation, transfer, keeping or receiving a child for purposes of exploitation.

What is exploitation?

Exploitation includes sexual exploitation, forced marriage, forced labour, child marriages, and using children in armed conflict, debt bondage, human sacrifice, harmful ritual practices, and sex tourism.

Is there a defence for child trafficking?

- There is no defence for child trafficking.
- It is not a defence that no force, threat, coercion, fraud, abduction, deception were used.
- Consent of the guardians of the child or the child to trafficking is not a defence.

When does the offence of aggravated trafficking occur?

a) Where the offence involves a child in armed conflict
b) Where any part, organ or tissue of a child is removed for human sacrifice
c) Where a child is used in the commission of an offence
d) Where the child is abandoned outside Uganda;
e) Where the body of the child is used for witchcraft, rituals or related practices;

What is the penalty for trafficking?

A person who commits an offence of aggravated child trafficking is sentenced to suffer death.

A person who commits an offence of ordinary trafficking is punishable by15 years of imprisonment.

What are the duties of the medical practitioner to support a victim of violence?

A health worker who suspects that a person under his or her care is a victim of domestic violence shall assist the victim in the following manner (sec.8):

a) Provide the required medical assistance
b) Accurately document the visit of the victim
c) Offer the victim options available within the legal system such as seeking legal advice or taking legal action. It is the victim's right to decide whether or not to pursue legal redress. *The health worker has no obligation to report abuse to the law enforcement agencies*.
d) In the case of a minor, the health workers must inform the parent or guardian
e) Make himself/herself available to testify in court, where necessary.

Session 2.6: Abortion and the Law

SESSION OBJECTIVES:

By the end of the session, participants will be able to:

1. Explain the national laws relevant to abortion
2. Discuss the relationship between rights and abortion.

What is abortion?

Abortion is the termination of pregnancy.

Is abortion a crime?

- Inducing abortion or helping another to have an abortion is a crime.
- However, abortion is not considered a crime where it is done to save the life of a woman.

Who can be charged of the charge of abortion?

The law punishes the pregnant woman and any person who helps her to either perform an abortion or supplies drugs to induce the abortion, as discussed here-below.

What are the ingredients/elements for the crime of abortion?

Section141: Punishes a person who helps a pregnant woman to abort by:

(i) Unlawfully administering anything

(ii) With intent to procure a miscarriage of a woman.

(iii) Proof that the woman was pregnant is not necessary.

The key elements here are the intention of the offender and the unlawfulness of the act of administering anything, to a woman which can cause an abortion, irrespective of whether the woman is actually pregnant or not.

Proof of pregnancy is not necessary. Even if the offender could have been mistaken or unsure at the time of his/her action, that the woman was indeed pregnant, so long as he attempts to induce an abortion the person will be charged of the offence.

Section142: punishes a pregnant woman who aborts:

(i) Knows that she is pregnant

(ii) Unlawfully does anything; or

(iii) Allows anything to be done to her

(iv) It must be proved that the woman was pregnant.

Section143: The law punishes a person (not the pregnant woman or the one who performs the abortion on her) who

(i) Supplies or procures anything

(ii) With knowledge that it is intended to be used for the abortion

(iii) The supply or procurement must be intended to procure a miscarriage.

(iv) Proof of pregnancy is not necessary.

The person supplying the drug must know that the drug, poison, or noxious thing was intended to be used to procure a miscarriage. Therefore the mere supply of something capable of inducing an abortion does not on its own make the supplier liable to an offence.

Section 212– Killing unborn child:

Another related crime is the killing of a child to be delivered, while the child is in the mother's womb.

However, the phrase 'about to be delivered is not explained'. In the Ugandan context it would be necessary to know whether a foetus below the viable period of 28 weeks would be interpreted to be an unborn child for purposes of section 212, since the law does not stipulate when life begins.

Are there any defences to abortion?

- Although the Penal Code does not authorize or legalise abortion, it provides a general defence of surgical operation under section 224.
- Sec. 224 provides a general defence for offences endangering life or health where death or injury occurs as a result of a surgical operation.

Section 224– Defence in cases of 'surgical operation':

"A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his or her benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time, and to all the circumstances of the case".

The law does not define surgical operation. However, the use of broad phrases such as 'good faith' reasonable care and skill', for his or her benefit', preservation of the mother's life', performance of the operation is reasonable', the patient's state at the time' and 'circumstances of the case' give the section a wide interpretation.

Surgical operation terminating the life of an unborn child for preserving the life of the

mother' is a legal defence.

The dictionary defines "*surgical abortion,*" as a medical procedure involving an incision with instruments; performed to repair damage or arrest disease.

What is the burden of proof for abortion?

- In reality abortion cases are difficult to prove because of lack of evidence:
- Abortion is done in extreme privacy
- All parties involved are responsible for the crime
- It is difficult to prove the cause of abortion whether it is spontaneous or induced. For example the medical drugs that induce abortion are also used for other diseases that it is difficult to prove that it was intended for abortion.
- The few cases successfully prosecuted involve death of the victim. However, they are charged as manslaughter and not abortion.

Is offering of Information and Counselling on Abortion illegal?

- Offering information on abortion is neither a criminal nor civil offence. Freedom of expression and association are guaranteed under Art 29. Therefore any person is free to express any opinion on abortion.
- The Maputo Plan of Action on Sexual and Reproductive Health and Rights, Strategic Objective 5, obliges governments to: Compile and disseminate data on magnitude and consequences of unsafe abortion; Undertake legal and policy reform to reduce unsafe abortion; Prepare national plan of action; Train service providers; Refurbish facilities to provide safe abortions, and Education of communities on importance to avail safe abortions. (Plan of Action on 2007-2010).
- The Reproductive Health Guidelines provide for the dissemination of information on abortion and the provision of Information, Education and Communication (IEC) materials with emphasis on:
  - *Common causes of abortion and their prevention*
  - *Awareness of the dangers of unsafe abortion*
  - *Post-abortion FP and counselling (breaking the cycles of abortion through using proper contraception)*
  - *Where to seek assistance and compliance to proper management*
  - *Early recognition and reporting of abortion and abortion-related complications*
  - *Self-care and expectations;*
  - *Availability of other SHR services*
  - *Rumours, myths and misconception on abortion*
  - *Harm reduction*

What rights are violated in the restriction of abortion?

- Right to life
- Right to health
- Right to non-discrimination
- Right to be free from cruel, in human and degrading treatment
- Right to dignity
- Right to privacy/reproductive self-determination
- Right to freedom of conscience

What are the rights violations which fuel need for abortion?

The need for abortion can stem from other rights violations namely:

- Sexual violence: rape, defilement and incest
- Lack of access to contraceptives, including emergency contraception.
- Lack of sexuality education.
- Discrimination against pregnant school girls and unmarried women.
- Restrictive gender roles and norms.

What is the impact of Criminalization?

- Can discourage women from seeking abortions
- Discourages providers from learning how to provide Comprehensive abortion care (CAC)or Post Abortion Care (PAC) services
- Deters women from seeking PAC because they fear arrest or abuse.
- Stigmatizes PAC regardless of whether abortion was spontaneous or induced.
- Governments are less likely to make necessary investments in training and equipment purchases.

In July 2010, the Government of Uganda ratified the Maputo Protocol. However, Uganda put a reservation on the individual right to abortion and the state's obligation to provide for it, unless—provided by domestic legislation expressly providing for abortion.

To date, there is no enabling law to operationalise Art 22(2) of the Constitution which provides that—No person has the right to terminate the life of a new-born child except as may be authorized by law Art14 of the Maputo Protocol provides for.

There is ambiguity about what is unlawful and what is lawful. The law only punishes the unlawful.

The law does not define the phrase 'about to be delivered'

The law does not define or make a distinction between the foetus, stillbirth or miscarriage.

Abortion or 'miscarriage' are used interchangeably, creating ambiguity and confusion.

The Constitution guaranteed the right to life and prohibits the termination of the life of an unborn child except as provided by law Art 22(2).

CRITICAL NEXT STEPS: ADVOCACY ON COMPARATIVE LAW

HARD FACTS

Maternal mortality rate with 336 per 100,000 women dying a year (UDHS 2016).

For every woman who dies, 6 survive with chronic or debilitating ill-health (Road Map 1).

Maternal and perinatal death account for 20.4% of deaths in Uganda compared to malaria15.4%, acute lower respiratory tract infections 10.5% and HIV/AIDs 9.1% (International Family planning Perspective 2005:1, Road Map 2007:9).

8% of the maternal mortality is due to unsafe abortion (Road Map, 2007:13-14).

An average of 300 abortion complication cases per day nationally (Guttermarcher 2005:59.

Providing safe abortion contributes to a cross section of MDGs, namely: women empowerment and equality, reducing child mortality and improving maternal health. It also indirectly contributes to other MDGs, such as achieving universal primary education, ensuring environmental sustainability and combating HIV/AIDs. (Guttmarcher2009)

The case of United Kingdom (UK) ***vs BOURNE***

[1938] 3 ALLER 615 is of persuasive value for the interpretation of the term to save the life of a woman.

A young girl of about 14 years of age was pregnant as a result of rape. A highly skilled surgeon performed the operation of abortion on her openly and free of charge in a London hospital. The surgeon was charged with unlawfully procuring the abortion of the girl under the existing anti-abortion law of 1861. He was found not guilty by the jury upon direction by the judge who interpreted the phrase "for the purpose of preserving the life of the mother" to include women's future physical and mental health:

"I do not think that it is contended that those words mean merely for the preservation of the life of the mother from instant death… The law is not that the doctor has got to wait until the unfortunate woman is in peril of immediate death and then at the last moment snatch her from the jaws of death… I think that those words ought to be construed in a reasonable sense, and, if the doctor is of the opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor, who, in those circumstances, and in that honest belief, operates, is operating for the purpose of preserving the life of the woman… Then too you must consider the evidence about the effect of rape, especially on a child, as this girl was, under the age of 15… no doubt you will think it is only common sense that a girl who for 9 months has to carry in her body the reminder of the dreadful scene and then go through the pangs of child birth must suffer great mental anguish, unless, indeed, she is a girl of very exceptional character."

In UK, the1967 UK Abortion Act legally allows abortion in specified cases.

a) Before 24 weeks if:
b) Continuance of the pregnancy injure the physical or mental health of the pregnant woman or any existing children of her family; or
c) Termination would prevent grave permanent injury to the physical or mental health of the pregnant woman; or
d) Continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
e) There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

In South Africa, The Choice on Termination of Pregnancy Act, 1996 allows abortion in the following cases;

a) It allows abortion on demand up to the twelfth week of pregnancy; an abortion may be performed at the request of the woman.
b) From thirteenth to the twentieth week, a pregnancy may be terminated if it endangers the woman's mental or physical health, if the foetus may suffer from a severe mental or physical abnormality, if the pregnancy resulted from rape or incest, or if it would significantly affect the woman's social or economic circumstances under broadly specified circumstances.
c) For serious medical reasons after the twentieth week, a pregnancy may only be terminated if it could endanger the woman's life, if the foetus is severely malformed, or if there is a risk of severe injury to the foetus

Art14 of the MAPUTO PROTOCOL provides for access to medical abortion in cases of sexual assault, rape, incest, and the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

MODULE 3
COMMUNICATION, PSYCHOSOCIAL AND MENTAL HEALTH COUNSELLING

DESCRIPTION OF MODULE

This module aims to empower health workers with knowledge and skills in communication and counselling. It focuses on importance of interpersonal communication and counselling in managing S/GBV and VAC/VAC survivors/victims. It also discusses the factors that facilitate effective counselling, interpersonal skills, qualities of a good counsellor and stages of counselling.

The module does not train providers to become clinical psychologists but introduces techniques that can be used in our health care settings for providing psychosocial and mental support to S/GBV and VAC/VAC survivor/Victim s. The module seeks to guide health workers who manage survivors/victims of S/GBV and VAC/VAC with knowledge of the possible mental and psychosocial manifestations amongst adults and child survivors/victims following sexual violence and provides them with skills on how to manage them and refer as found necessary.

Trainees are helped to begin identifying and understanding the depth and effects of trauma posed on the minds of survivors/victims as a result of S/GBV and VAC. Special emphasis is laid on children who experience significant psychological and emotional distress during the most critical period of their lives. Trainees are helped to appreciate the three stage process of mental health manifestations; and be able to use it to structure the healing process. Overarching guiding principles and key international human rights standards related to sexual violence against children are also introduced. Counselling skills are applied throughout the process of helping the survivor/victim that include being non-judgmental, having supportive attitudes and basic trauma-focused cognitive behavioural therapy techniques, that facilitate psychological processing and confronting fears after the S/GBV in both adults and children.

This module will include the following sessions:

Communication and counselling for S/GBV survivors/victims

1. Psychosocial and mental health manifestations of S/GBV
2. Managing psychological and mental health effects of sexual violence against children

MODULE OBJECTIVES

1. Appreciate the importance of communication and psychosocial counselling and mental health support during management of sexual and gender based violence survivors/ victims
2. Demonstrate ability to provide psychosocial counselling and mental health support to survivors/victims of sexual and gender based violence in both adults and children

SESSION 3.1 COMMUNICATION AND COUNSELLING FOR S/GBV and VAC SURVIVORS/VICTIMS

Objectives

By the end of the session, the participants will be able to:

1. Define communication and interpersonal communication
2. Discuss the interpersonal communication process and skills
3. Discuss the Importance of communication
4. Define counselling
5. Discuss the importance of counselling and inter-personal communication in S/GBV and VAC
6. Discuss the factors that facilitate effective counselling
7. Explain the stages/process of counselling in S/GBV
8. Demonstrate ability to counsel S/GBV/ VAC victim/survivor/Victim s

MEANING OF COMMUNICATION

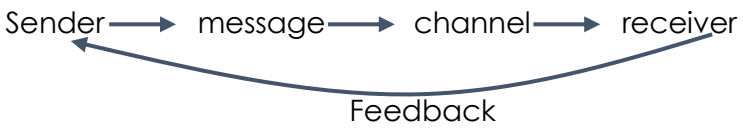
Communication is a two-way process whereby information, message or thought on a particular topic is passed on from sender to the intended receiver through words, actions or signs and intended receiver sends a feed back to the sender.

C

ommunication occurs when people create, send and receive messages; share ideas or thoughts and react to messages. During communication, people may wish to express their feelings or emotions and it involves the sharing of information with other people to reach a common understanding.

Effective communication has been found to lead to positive changes in the use of reproductive health services.

- **The communication process involves:**



Verbal communication skills (acronym CLEARRS)

C *Clarification using open-ended or probing questions*

L *Listening actively/allowing client to finish speaking*

E *Encouragement/praise*

A *Accurate reflection and focusing of the discussion according to the client's concerns*

R *Repetition/paraphrasing*

R *Responding to client's non-verbal communication*

S Summarising and ensuring a common understanding of discussion

Non-verbal communication skills (using the acronym SOLER)

S *Smile/nod at client*

O *Open and non-judgemental facial expression*

L *Lean towards client*

E *Eye contact in a culturally acceptable manner*

R *Relaxed and friendly manner*

Written and visual communication skills

This may be demonstrated using writing, drawing of pictures to express feelings, emotions, thoughts and ideas.

Other factors that facilitate better counselling are similar sex, age, culture, religious affiliations and social economic status. Personal traits/mannerism, superiority/inferiority complexes are likely to negatively influence counselling.

Meaning of inter personal communication

- Is a verbal or non-verbal exchange of information between two or more people.

MEANING OF INTERPERSONAL COMMUNICATION PROCESS

Is a two-way, interactive cycle in which communicators exchange messages. All parties involved are both senders and receivers. In this process the receiver interprets previous messages and responds with new messages. The messages communicated are both verbal and non-verbal.

THE STEPS OF INTERPERSONAL COMMUNICATION PROCESS

- **Assess**

  The service provider collects information about client's culture, past experience, attitudes and knowledge towards Reproductive Health Services (RHS).

- **Analyse**

The service provider interprets the information gathered about the client or the audience to identify information needed e.g. in antenatal clinic, provider gets history from pregnant mothers interprets, and identifies what other information they need to assist them in making decisions.

- **Communicate**

  The plan is put into action. Service Provider shares with the client her/his understanding of the problem and possible plan of action..

- **Evaluate**

  The service provider determines the effectiveness of the communication (i.e. was the client interested? Was the message understood? Will the client act on the information?).Results will assist the service provider how to improve communication with others.

IMPORTANCE OF COMMUNICATING IN S/GBV

Good interpersonal communication skills will help health workers to better satisfy the needs of S/GBV and VAC clients. Good interpersonal communication skills help to bring the client closer to the service provider because of the helpful environment created.

- To create awareness about S/GBV and VAC
- To give proper and correct information that allows individuals/communities to make decisions in preventing and reporting S/GBV and VAC.
- To encourage men, women, young people and children to seek for medical and legal services.
- To advocate for S/GBV and VAC services.

DEFINITION OF COUNSELLING

Counselling is a face-to-face communication between a service provider and one or more people where the service provider helps the individual or group of people to make a decision(s) and act on it/them. Through the counselling process survivors can overcome their problems. Counselling empowers survivors and care takers to deal with fear, shock, and anger, among others.

FACTORS THAT FACILITATE EFFECTIVE COUNSELLING

- **Privacy and confidentiality**

  The counsellor should be a person who is able to keep secrets. Any person who finds it hard to keep information concerning his/her client's problems cannot make a good counsellor.

  For counselling to be fruitful and meaningful, the client should feel safe to talk about issues that he/she might not have discussed elsewhere. The client has to be assured of confidentiality and in cases where total confidentiality is not possible; for example if the issue at hand has to proceed to the police or courts of law, the counsellor should inform the client.

- **Being flexible and patient**
- **Accuracy and completeness of information**
- Provide sufficient factual information to the client so as to avoid information overload. Remember not to talk too much! **Use of language understood by client**
- **Positive counselling attitudes**
  - Respectful of client's age, sex, education level, situation, etc.
  - Caring
  - Non judgmental
  - Empathetic (being able to see the situation through the others' eyes)
  - Showing concern and willingness to help
- **Effective interpersonal communication skills**

COUNSELLING ATTITUDES

- **Non judgemental**

  The counsellor should use non-judgmental language and posture. Leaning forward communicates involvement and interest in what the client is saying. Leaning back usually communicates a judgmental attitude and a lack of interest in what the client is communicating. Make sure your posture does not intimidate the client.

  Fidgeting or restlessness gives the client an impression that the counsellor has no time to listen or that it is his/her problem that has caused you to be unsettled. Fidgeting around in one's chair, reaching out for a book, holding newspapers or writing may communicate to the client that the counsellor is impatient and would like to move to something else. Such behaviour interrupts the client's communication.

- **Empathetic**

  This is the act of seeing things from a client's perspective or point of view. It implies trying to see and feel how it is for the client who is in that situation. This requires the counsellor to understand and appreciate the client's feelings. It also demands that a counsellor takes careful attention to what the client is saying in

order to understand how things are for the client. This has to be communicated to the client.

- **Showing care, concern and willingness to help**

  Nearly all health workers have a busy client schedule and load and might fail to create time to be available to help and support S/GBV and VAC victims/survivor/Victim s. Nevertheless, a counsellor has to be available, approachable and committed to receive and attend to S/GBV and VAC clients.

- **Being friendly**

  This refers to the mutual friendship, care and concern to the client. The counsellor has to approach the client as a unique person with a unique problem. There has to be willingness on the part of the counsellor to help the client. The counsellor has to be warm and open towards the client and has to be non-defensive.

- **Openness**

  The counsellor has to be true to oneself and to the client, i.e honesty and not to make empty promises

- **Respectful**

  Respect clients for who they are regardless of their sex, age, background, social-economic status, etc. This can be expressed through verbal and non-verbal communication

COUNSELLING PROCESS

Preparation

In preparation for counselling ensure the following:

- Suitable room/place to ensure privacy and confidentiality
- Convenient time for both provider and client
- Comfortable and conducive sitting place
- Alert others not to interrupt
- Have all the necessary visual aids

Stages of counselling

There are three stages in the counselling process;

- **Stage one**

  During this stage the counsellor helps the client to tell their story or share his/her problem. This requires giving the client a warm welcome, putting aside everything the counsellor is doing to attend to the client. The counsellor has to listen actively. Listen to the client and use verbal and non-verbal responses. The body language of the counsellor has to show interest in what the client is saying. The major focus of this stage is to find out what the problem(s) is, the information that the client has about the problem and how she has tried to deal/cope with the problem.

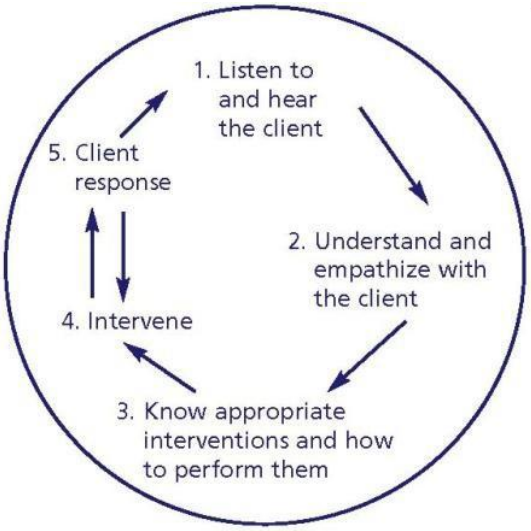
- **Stage two**

  During this stage the counsellor helps the client to consider the implications of each option. The client should be encouraged to try and imagine what would possibly happen when a given option is taken. In this stage the counsellor may provide information that is needed at various points. The major focus in this stage is to help the client think of a number of ways of coping with the problem(s) by considering the implications of each option and coming to a point where the client is in position to choose which course of action to take.

- **Stage three**

  During this stage a client is helped to make a plan. The counsellor helps the client to make a plan as to how the action is going to be implemented. The plan provides the client with a step-by-step program on what to be done to accomplish the task. At the end, the plan is summarized for the client and encouraged to implement it. The client is encouraged to come back and inform the counsellor how the plan has worked out. This plan is important to the client because clients may be overwhelmed by a certain problem and may need a clear action plan to motivate them towards solving a problem.

Process/stage cycle



Points to note during counselling

- Minimal responses should come at regular intervals and should be spaced in such a way that they do not become intrusive or distracting.
- Minimal responses have to match the speed and pace of the client for example an agitated client demands the same pace from the counsellor. The counsellor's tone has to match the client's tone. The counsellor should try to move along with the client until it is appropriate to speed up or to slow down a client.
- The body of the counsellor is very important during the use of minimal responses. The counsellor has to try to be simple and spontaneous in both facial and body posture. The counsellor has to control distracting expressions e.g. swinging around, crossing legs or inappropriate dressing.
- A counsellor can use longer statements in order to break the monotony of the brief

statements from time to time.

- A counsellor has to maintain good eye contact especially when building rapport. This eye contact should be natural. The counsellor should avoid staring at the client.
- Allow silence; a counsellor should not try to cover all the silence with minimal responses.
- Allow the client to cry if they want to cry.

Don'ts during counselling

- Avoid giving advice; help clients to work through issues and to make their own decisions.
- Do not pretend to be having skills, knowledge or other resources.
- Know where and when to refer clients for further or more specialized help.
- Do not minimize and judge how big or how small client's problems are.
- Do not try to prioritize their concerns.
- Do not assign blame.
- Avoid asking the why question and accusing questions.
- Do not be judgmental.
- Do not be personal (maintain a professional provider-client relationship).
- Do not break down to a hear-trending story; be in control of your emotions.
- Do not interrogate the client.
- Do not refer without consent.
- Avoid controlling what the client has to say.
- See special considerations when counselling a child or adolescents in session 3.3

SESSION 3.2: DEALING WITH PSYCHOSOCIAL AND MENTAL HEALTH MANIFESTATIONS OF S/GBV and VAC

Session objectives

By the end of the session, participants should be able to:

1. Explain the relevance of psychosocial support in care of S/GBV and VACsurvivors/victims
2. Discuss possible psychological/mental health manifestations of S/GBV/VAC
3. Explain the three-stage process that occurs as a result of sexual violence or attempted sexual violence (behaviour and outcome)
4. Discuss counselling of adultswith psychological/mental health manifestations after experiencing Sex and Gender based violence

Introduction:

Health workers are encouraged to provide psycho-social support including counselling to survivors/victims of sexual violence and violence against children as well as the perpetrators.

Most survivors/victims of sexual violence will regain their psychological health through the emotional support and understanding of individuals they trust, community counsellors, and support groups. At this stage, ensure that the survivor/victim is not pushed to share personal experiences beyond what she/he wants to share. However, the survivor/victim may benefit from counselling at a later time and survivor/Victim s/victim should be referred for more counselling to agencies that exist in the area who offer counselling services.

Relevance of psychosocial support in care of S/GBV and VAC survivors/victims.

It is important for the health workers to note that if the survivor/victim has symptoms of panic or anxiety, such as dizziness, shortness of breath, palpitations and choking sensations, that cannot be medically explained (i.e. without an organic cause), explain to him/her that these sensations are common in people who are very scared after having gone through a frightening experience. This is due to psychological trauma. The symptoms reflect the strong emotions the survivor/victim is experiencing and may go away overtime as the emotions decrease. There is need to refer the person to a professional trained in mental health for re-assessment.

Psychological/ mental Health manifestations of S/GBV and VAC

Symptoms of trauma can be wide and varied and differ from person to person. A traumatized individual may suffer from one or several of the following symptoms and the list is not exhaustive.

- Upsetting memories such as images, thoughts or flash backs
- Nightmares
- Insomnia
- Re-experience of the trauma mentally and physically
- Emotional detachment (known as dissociation)
- Individuals may turn to alcohol and/or drugs or substance abuse
- Stress/anxiety disorders
- Panic attacks
- Anger
- Despair
- Depression
- Loss of self-esteem
- Feelings of guilt and shame
- Uncontrollable emotions, such as fear, anger, anxiety
- Suicidal thoughts or attempts
- Numbness
- Sexual dysfunction
- Medically unexplained somatic complaints

Mental health/psychosocial consequences of S/GBV and VAC

Immediate reactions after a sexual violence experience may vary. Some violence survivors/victims remain controlled, numb, in shock, denial and disbelief. They present a flat affect, quiet, reserved and have difficulties expressing themselves. Other violence survivors/victims respond quite differently- being very expressive and verbalizing feelings of sadness or anger. They may appear distraught or anxious and may even express rage or hostility against the medical staff attempting to care for them.

Period	Mental health effect/complication on S/GBV and VAC Survivor/victim	Factors that may aid or inhibit the survivor/Victim 's ability to resolve the issues associated by the violence
Immediate reactions after a sexual violence	Survivor/Victim s remain controlled, numb, in shock, denial and disbelief Others respond quite differently - being very expressive and verbalizing feelings of sadness or anger. May appear distraught or anxious may express rage or hostility against the medical staff attempting to care for them	Positive feelings of self-esteem, good support systems, previous success in dealing with crisis Economic security will enhance her / his ability to heal. Dealing with one small segment of the problem at a time - often gain self-confidence and are able to make decisions. For children- support of the parent or guardian, peers and teachers Lack of support systems Negative self-esteem
Long term reactions	- Survivor/Victim s may display maladaptive methods such as - indulging in drugs and alcohol, becoming promiscuous or abusive themselves, chronic stress - Perfoming poorly in school - Seeking revenge - Post-Traumatic Stress Disorders that include: - phobia and panic disorders - sexual dysfunction - eating disorders - behavioural disorders - Depression **NOTE**: Risk factors for PTSD - More (persistent) PTSD symptoms are associated with: - assault with a weapon or more violent rape - location of rape thought to be 'safe' - less education - more self-blame - less social support - Survivor/Victim – perpetrator relationship had little impact on symptoms, and they can actually be worse with marital rape	

Various factors may aid or inhibit the survivor/victim's ability to resolve the issues associated by the sexual violence. Positive feelings of self-esteem, good support systems, previous success in dealing with crisis and economic security all enhance her/his ability to heal. Survivors/victims who can deal with one small segment of the problem at a time often gain self-confidence and are able to make decisions.

However, survivors/victims who suffer chronic stress and lack of support systems are less able to resolve their issues. Negative self-esteem often hinders their progress and paralyzes their efforts. These survivors/victims often use maladaptive methods such as indulging in drugs and alcohol, becoming promiscuous or perpetrators themselves, etc. to deal with the stress. These factors hamper their ability to resolve and move beyond the issues of the sexual violence.

The three-stage process,

The three-stage process or syndrome, that occurs as a result of sexual violence or attempted sexual violence include:

1. **The Acute Stage**

   This stage occurs immediately after the assault. It may last a few days to several weeks. It is characterised by;

   1. Agitation
   2. Shame or/ and Withdrawal
   3. Hysterical or totally calm indicative of shock
   4. Crying spells and anxiety attacks.
   5. Difficulty in concentrating, making decisions, and dodging simple, everyday tasks.
   6. Show little emotion; act as though numb or stunned.
   7. Signs of resentment or hate of anyone with characteristics similar to perpetrator e.g. same sex, profession etc
   8. Poor recall of the sexual violence or other memories.

   Outcome

   - Survivor/Victim s can adapt and seek help
   - Others especially children may fear to talk about it . They may develop new behaviours like being aggressive, abusive, disobedient and rude etc..
   - Some may get into denial,frequently mask the under lying problems and act normal. Some adults may fail to resolve

2. **The Outward Adjustment Stage**

   a. Some blame themselves and may make dramatic changes in lifestyle or environment:

      1. May quit a long-standing job. For children may hate education and stop schooling or family life and divert from known cultural norms.

2. Move to a new location to get a fresh start. For children, they may decide to live on streets or become prostitutes
3. May change their physical appearance or behaviour e.g. Cut their hair, bleach themselves or even seek plastic surgery.

However, health workers should note that none of these changes bring about the internal security that the survivors/victims need to cope. Nightmares and phobias may emerge.

Internal insecurity can manifest itself by the following behaviours or experiences:

(i) Continuing anxiety.
(ii) Sense of helplessness.
(iii) Persistent fear and/or depression.
(iv) Severe mood swings (e.g. happy to angry, etc.)
(v) Vivid dreams, recurrent nightmares, insomnia.
(vi) Physical (psychosomatic) ailments.
(vii) Appetite disturbances (e.g. nausea, vomiting, compulsive eating).
(viii) Efforts to deny the assault ever took place and/or to minimize its impact.
(ix) Withdrawal from friends and/or relatives.
(x) Pre-occupation with personal safety.
(xi) Reluctance to leave the house and/or to go places which remind the survivor/victim of the sexual violence.
(xii) Hesitation about forming new relationships with men/women and/or distrustful or existing relationship.
(xiii) Sexual problems.
(xiv) Disruption of normal everyday routines e.g. high absenteeism at work suddenly or, conversely, working longer than usual hours; dropping out of school; travelling different routes; going out only at certain times.
(xv) Psychosomatic manifestations. For children hysteria or convulsive disorders

Sexual Violence Trauma Syndrome:

Resurfacing of second stage symptoms indicates emergence of sexual violence trauma syndrome. Clients are more likely to disclose than deny the situation and are more receptive to counselling and show feelings and emotions associated with the sexual violence. Symptoms could be overwhelming because of suppression for a long time.

Some sensory stimulation triggers flashbacks characterized by nightmares, phobias, depression, anxiety, sexual dysfunction monopolize her/his thoughts.

Ready to seek therapy.

NB: For children, persistent probing by guardian/ parent or counsellor may result into disclosure of further details - in bits and pieces. Children may need cues to enable their retrieval of memory.

The stages are not linear and can vary as the survivor/victim works their way through. Survivors/victims find themselves taking one step forward and two back as they move back and forth, vacillate between stages and labour to find their way.

3. The Resolution Stage

During this stage the sexual violence is no longer the central focus in the survivor/victim's life. The survivor/victim begins to recognize that while s/he will never forget the assault, the pain and memories associated with it are lessening. S/he has accepted the sexual violence as a part of her/his life experience and is choosing to move on from there. Some of the behaviours of the second stage may flare up at times but they do so less frequently and with less intensity. In this fashion the person who has survived has moved from being a—victim "to a "survivor".

Counselling of adults with psychological/mental health manifestations after experiencing Sexual and Gender based Violence

Survivor/Victim s of Sexual and Gender based violence face various forms and degrees of psychological and mental health problems some of which may require special management.

Survivor/Victims of S/GBV and VAC may present with the different manifestations. The common ones include: fear, stress and anger. Discussed below are the guidelines to follow while handling the survivor/victim with any of the above manifestations.

1. **Fear**

- Explain that there ar

  e ways to confront and overcome fears that are better than avoidance in the long run.
- Help the survivor/victim make a list of things that cause fears,arrange them from those that cause minor to major fears. Prompt from knowledge of sexual assault history.

  NOTE *that everything survivors/victims fear need to be listed right from the beginning and new issues can be added later.*
- Some fears need to be confronted in stages and one at a time until she/he feels comfortable and when the first level has been achieved ,then you can move to the next which should be less protected and confrontation should be attempted.
- In a safe environment deliberately help the survivor/victim to confront situations they find fearful and have been avoiding because they provoke memory of the sexual abuse and work through the avoidance.
- Allow moments for the survivor/victim to go back to the moment and recount the traumatic experience.
- Let her/him speak/write their thoughts and feelings at the time of the trauma.
- When a fear has been successfully overcome, another one from the list should be attempted.
- This narrative should be repeated until the distress that is evoked bythe fear is reduced.
- Survivor/Victim s may feel frightened about re-living the experience and good

preparation by explaining that this can help overcome the fear is important

- Encourage her/him to confront the exposure e.g. leaving home with a trusted friend.
- Explain that there are ways to confront and overcome fears that are better than avoidance in the long run.

2. **Stress**

Four Principles to manage stress (4As)
1. Avoid stressful situations
2. Alter situations
3. Adapt to situation
4. Accept the situation

- Help survivor/Victim s cope with daily feelings of anxiety so as to decrease the likelihood of experiencing anxiety symptoms.
- Help the survivor/victim with relaxation and deep breathing exercises–consciously relaxing muscles; for example:
  - Breathing–deep, slow abdominal breathing (avoid hyper ventilation)
  - Breathing can help with relaxation and bring about a sense of control and is very easy to do and teach
- Breathe in and out normally
- Breathe into a count of 4
- Breathe out to a count of 4
- Encourage Positive thinking/self-talk–e.g. I did it before, I can do it again

3. Anger

Discuss the following on feelings of anger:

- Survivor/Victim s, parents and partners often feel angry and have feelings of wanting to take violent actions like revenge, causing injury, committing suicide, killing, etc.
- Discuss the above feelings and validate them
- Distinguish between feelings and actions
- Emphasise that it is not acceptable to take violent action
- Explain that action can be taken through the law
- Parents should keep their strongest anger feelings away from children but it is appropriate to show grief and sadness at what has happened to the child
- Make a summary of important tissues to be included/ensured during psychosocial counselling of Sexual and Gender based violence and violence against children victims/survivors

WHAT TO DO WHEN FACED WITH ANGRY SURVIVOR/VICTIMS

- Acknowledge the anger
- Reassure that together with the survivor/victim you will see how to manage the anger step by step.
- Find out what the survivor/victim wants to do with the anger
- Discuss with them the various ways like exploring the consequences of their actions, doing energy burning physical activities such as jogging, listening to music, taking a deep breath (pre-occupation).

TRAUMA COUNSELLING

Psychological trauma occurs as the result of a traumatic event; an experience or enduring event(s) that completely overwhelm our ability to cope or understand the ideas and emotions involved with that experience. These experiences are so far outside of what we expect that the events provoke reactions that feel strange to us. These reactions may be unusual and disturbing but they are expected responses to abnormal events.

Traumatic experiences make us question our beliefs about safety and destroy our assumptions of trust.

DISCUSSING POST-SEXUAL VIOLENCE EXPERIENCE

It is very important that the survivor/victim sets the boundaries and only does what she/he feels comfortable with.

- Sexual expectations and behaviour cause great anxiety because they bring back the memory of the sexual violence
- Ask survivor/victim whether thoughts are about re-establishing intimate relationships
- Allay anxiety/fear of intimacy and reassure that they don't have to do anything until they are ready
- Mention that all acts of intimacy can be expressions of love, its not just about penetrative sex.
- Suggest that survivors/victims start gradually with non-sexual touching and when they are comfortable gradually include kissing, sexual touching, etc.

THE KEY ISSUES TO CONSIDER DURING COUNSELLING

- Understanding psychological and mental health consequences of sexual abuse
- Stress management
- Offer on-going supportive counselling and arrange for other support as appropriate, depending on Mental health complications of sexual violence:
- Post-Traumatic Stress Disorders
- Phobia and panic disorders
- Sexual dysfunction

- Eating disorders
- Behavioural disorders
- Depression

Ask the survivor/victim if he/she has a safe place to go to and if someone s/he trusts will accompany her/him when s/he leaves the health facility. If s/he has no safe place to go to immediately, efforts should be made by the relevant authorities to find one for her/him. Help client seek assistance of the counselling services, community services provider and law enforcement authorities including police or security officers as appropriate. If the survivor/Victim has dependants to take care of and is unable to carry out day-to-day activities as a result of her/his trauma, provisions must also be made for her/his dependants and their safety.

Acknowledge that the survivor/victim could have experienced serious physical and emotional events. Explain to the survivor/victim about the psychological, emotional, social and physical problems that s/he may experience. Explain that it is common to experience strong negative emotions or numbness after sexual violence.

Explain to the survivor/victim that s/he needs emotional support. Encourage him/her to ask for emotional support from a trusted family member or friend. However, do not force him/her-to confide in someone s/he does not trust. Encourage active participation in family and community activities.

Involuntary orgasm can occur during sexual violence, which often leaves the survivor/Victim feeling guilty. Reassure the survivor/victim that, if this occurred, it was a physiological reaction and was beyond his/her control.

NOTE:

In most cultures, there is a tendency to blame the survivor/Victim in cases of sexual violence. If the survivor/victim expresses guilt or shame, explain gently that violence is always the fault of the perpetrator and never the fault of the survivor/Victim. Assure him/her that s/he did not deserve to be sexually assaulted, that the incident was not their fault, and that it was not caused by her behaviour or manner of dressing. Do not make moral judgement of the survivor/Victim.

Note: treat acute presenting symptoms such as panic attacks, shock etc. with minor tranquilizers (sedatives)

The duration of the treatment will vary with the medication chosen and the response. In a few cases the symptoms may not resolve but complicate to post traumatic stress disorder (PTSD); in such a case refer for psychiatric care and management. Furthermore, some clients might present with suicidal symptoms such as expression of self-blame, hopelessness, worthlessness, desire to die etc. These expressions should be taken very seriously by ensuring the survivor/victim will not harm him/herself and refer for psychological counselling.

Note: Medication used for managing psychosocial and mental health Problems related to S/GBV and VAC are addressed in Module 4 (Clinical management)

SPECIAL CONSIDERATIONS FOR COUNSELLING MEN WHO HAVE BEEN SEXUALLY ABUSED

When a man is sodomised, pressure on the prostate can cause an erection and even orgasm. Reassure the survivor/Victim that, if this has occurred during the acts of sodomy, it was a physiological reaction and was beyond his control.

Male survivors/victims of sexual violence are even less likely than women to report the incident, because of the extreme embarrassment that they typically experience. While the physical effects differ, the psychological trauma and emotional after-effects for men are similar to those experienced by women.

However, if the sexual violence occurred less than 2 to 3 months ago and the survivor/victim complains of sustained, severe subjective distress lasting at least 2 weeks, which is not improved by counselling and support and asks repeatedly for more intense treatment and you cannot refer her, consider a trial with available anti-depressant. Watch out for side-effects, such as a dry mouth, blurred vision, irregular heart beat and light-headedness or dizziness, especially when the person gets out of bed in the morning.

Scenario 1:

Client

Lesama is 19 years old female, a good Christian in secondary school. One day as she went back home after a school dance, she was gang raped by 5 fellow students and left in the bush. The rapists didn't use condoms. Lesama has been brought to your health facility by the mother three days after the incidence. The mother tells you that she has not talked or slept well but only cries.

Service provider

Identify what stage Lesama is at and provide psycho social counselling to Lesama and her mother

Scenario 2:

Tarisa has come to you for help. She is very angry and worried. She says that one night her boyfriend Mwangi asked her to stay at his house. She had a headache and did not feel like a night in his bed. She told him that she was not well and she would see him the next day. The next thing she knew, Mwangi and three of his friends came into her room and took her bag and ran away laughing. She needed the bag the next day so she went to Mwangi's house to get it back. As soon as she entered, he threw her on the bed and had rough sex with her even though she said "No" and resisted. "That will teach you not to say no to your man when he needs you" Mwangi said.

Tarisa was in pain and felt like rubbish. Mwangi did not use a condom. You are the SGBV counsellor and Tarisa is seeking your help a day after the rape because she is afraid.

What would you do for her?

Scenario 3

Akili has visited your clinic for the second time. During the first visit, Akili complained of headache, unexplained body pains, and failure to sleep. She has visual disturbances and sees men coming to strangle her in her dreams.

Akili has come again and Ass you talk to her you find out that Akili is 30 years and was raped by her boss two years ago, an old man whom she respected a lot. Since then she has had episodes of compulsive eating and has gained a lot of weight. She left the job and moved to another town. She hates men and doesn't trust them. She has failed to get employment because she always thinks it will happen again. She has not been in any relationship and has not had any sexual relationship.

How would you help Akili?

SESSION 3.3: MANAGING PSYCHOLOGICAL AND MENTAL HEALTH EFFECTS OF SEXUAL VIOLENCE AGAINST CHILDREN

Session objectives

By the end of the session trainees will be able to:

1. Discuss psychological and mental health complications among children who have suffered sexual violence.
2. Discuss the guiding principles and human rights standards when dealing with psychological and mental manifestations following sexual violence against children.
3. Discuss how to counsel children with psychological and mental health manifestation due to sexual violence.
4. Apply counselling skills and human rights principles to counsel child survivors/victims of sexual assault with mental health and psychosocial manifestations.

PSYCHOLOGICAL AND MENTAL HEALTH COMPLICATIONS AMONG CHILDREN WHO HAVE SUFFERED SEXUAL VIOLENCE

Children experience significant psychological and emotional distress but unlike adults, they are traumatized during the most critical period of their lives. This is the period when:

- Assumptions about self, others and the world are being formed.
- Their relations to their own internal states are being established.
- Coping and relationship skills are first acquired.

Children also develop post-traumatic stress disorder and display them differently according to different age ranges; for example;

- From age 8-10 years: symptoms are like those found in adults
- Age <8 and particularly <5 years: symptoms less clear, often no overt distress
- However some noted behaviours include:
  - regressive behaviour
  - new fears
  - overt aggressiveness / destructiveness
  - repetitive play about traumatic event
- One should consider the level of behaviour e.g. assaulting another child vs. mild repetitive play when considering the need for treatment

Therefore, the Post Traumatic Stress reactions impact upon the child's subsequent psychological and social maturation leading to a typical and potentially dysfunctional development. In other words, if untreated, the effects of sexual violence in childhood are usually more dynamic and interactive, in contrast to trauma effects in adults who have a stable base development and maturation to draw on and for whom, with support, the trauma effects will wane overtime.

If untreated, the effects of sexual violence in childhood are usually more dynamic and destructive, in contrast to trauma effects in adults who have a stable base developed and matured.

The impact of defilement/sexual assaults on mental health of child survivor/Victim s may include:

Acting out & testing boundaries

- Children may act out things that happened during rape e.g. play at tying themselves up
- They may be generally or sexually aggressive and may engage in inappropriate sexual behaviour (which may be a form of acting out)
- Ask parents if they have noticed changes in behaviour
- Parents should keep the rules of the home the same and handle aggressive behaviour in the same way they would if the child was not abused
- Communicate that aggression is not acceptable
- Parents should be careful not to instill guilt by linking sexual acting to why they were raped

Clinging behaviour

- Many abused children display clinging behaviour. They want to stay very close to their parents & want to be cuddled, perhaps at inappropriate times, they want to share bed with parents, etc.
- Ask parents if they have noticed such a change
- Explain that abused children have need for comfort, closeness & safety, parents should not fight it – let them stay close,
- Older children should be given special time if they start feeling excluded or jealous

Parents or guardians may be included or the ones counselled especially in cases of young children; the following points may be used during counselling:

- Parents may feel guilty that they couldn't protect their child
- Guardian and parents' feelings should be acknowledged
- The survivor/Victim or their parents are not to blame for the rape
- Parents may be encouraged to think about how they can provide more supervision for the child to reduce future vulnerability, if this is relevant for the particular case
- Parents may worry that the child is lying
- Parents should know that children rarely know enough to make up details of sexual abuse. Children rarely lie about abuse & and are not likely to deny or hide it

GUIDING PRINCIPLES AND HUMAN RIGHTS STANDARDS FOR SEXUAL VIOLENCE AGAINST CHILDREN

Based on the United Nations convention on the rights of the child (CRC) and other human rights standards the following overarching principles need to be observed when providing care to children and adolescents who have or may have been abused.

(i) Attention to the best interests of children or adolescents by promoting and protecting safety; providing sensitive care; and protecting and promoting privacy and confidentiality.

(ii) Addressing the evolving capacities of children or adolescents by providing information that is appropriate to age; seeking informed consent as appropriate; respecting their autonomy and wishes; and offering choices in the course of their medical care, as appropriate.

(iii) Observing non-discrimination in the provision of care, irrespective of their sex, race, ethnicity, religion, sexual orientation, gender identity, disability or socioeconomic status.

(iv) Ensuring the participation of children or adolescents in decisions that have implications for their lives, by soliciting their opinions and taking those into account, and involving them in the design and delivery of care.

COUNSELLING CHILDREN WITH PSYCHOLOGICAL AND MENTAL HEALTH MANIFESTATION DUE TO SEXUAL VIOLENCE

The key objective of counselling intervention with survivors/victims of childhood sexual violence is to facilitate trauma resolution and foster healing and growth.

This happens in phases:

Counselling phases and structuring the healing process

The early phase of therapy with survivors/victims of childhood sexual abuse focuses on building up trust between the counsellor and the survivor/victim and prepare the survivor/victim for the healing process. During this phase of therapy the survivor/victim is encouraged to tell their story which allows the counsellor to assess which of the sexual violence techniques may be the most beneficial.

Telling their story is difficult for some survivors/victims. Their memories are fragmented and all jumbled up making it hard for them to relate what happened when. There is often a feeling of being overwhelmed by the abuse and just not knowing how to start. Many survivors/victims just can't differentiate between episodes of abuse and their whole sense of childhood was taken over by it. At this stage there are tools which can be used to help the survivor/victims put their childhood back together into a recognisable whole by focusing on specific incidents or episodes of their lives to structure their stories.

The middle phase of therapy is where the brunt of the work is done which includes re-processing the trauma. Simply stated, processing the trauma of childhood sexual assault involves:

1. Acknowledging the fact of the abuse and its impact.
2. Experiencing and releasing some of the feelings associated with the trauma that typically has remained unexpressed.
3. Exploring a range of feelings towards the abuser/s and non-protective parents, siblings or caretakers; and
4. Making cognitive reassessments of the abuse (i.e. why it happened, who was responsible etc.)

If these avenues are explored, the traumatic events are faced and processed. The abuse can no longer remain frozen in time and continue to maintain the survivor/Victim's beliefs about vulnerability, helplessness, mistrust, stigmatisation, with a negative view of self and others.

Emphasis is also placed on cognitive restructuring, educating the survivor/victim and the formulation of new coping strategies. Through this sort of trauma processing a clear line is drawn between the past and the present leaving the individual feeling more in control and determined to deal with the impact the abuse has on their lives.

It is at this stage that new coping skills can be incorporated into the behavioural patterns of the survivor/Victim s. At this stage the survivor/victim actively engages in making decisions to heal and appreciate the options open to them. This is also a stage of exploration of possibilities which can lead the survivor/victim further along the path of re-integration.

The last phase of the healing process is the termination phase. This involves empowering the survivor/victim to make their own choices and decisions without relying on the counsellor. It includes the survivor/victim's separation from the counselling process while establishing support networks. These might include self-help support groups as well as supportive friends, partners, or family members.

COUNSELLING APPROACHES TO CHILDHOOD SEXUAL ASSAULT

Counselling survivors/victims of childhood sexual assault incorporates a number of the sexual violence therapeutic approaches: emotional, cognitive and behavioural.

Experiential or exploratory techniques focus on accessing emotions, re-experiencing the trauma and integrating these with the adult self.

Cognitive therapy aims to identify the survivor/victim's distorted cognitions of themselves, others and the world and attempts to replace these with more accurate and realistic cognitions.

Behavioural therapies focus on enhancing the survivor/victim's behavioural rapport through the acquisition of more adaptive behavioural responses, coping strategies and learning new skills.

Special consideration for communication and counselling children

Children are at greater risk of S/GBV and VAC due to their age, minimal knowledge of risky situations, status in the community and economic vulnerabilities. Similarly, they have many emotional challenges and concerns to deal with on a day-to-day basis which they might fail to communicate. It is therefore extremely important to provide them with proper emotional care and counselling because it will help them understand that the trauma was not their fault and to address any fear or anger they are feeling.

Role play scenarios

Scenario 4:
A 7 year old girl is brought in the clinic by her mother. The mother informs the health worker that the girl has vaginal discharge and sores in her private parts and also walks with difficulties. She has failed to talk for the last 2 days and is withdrawn.
The health worker has taken history and examined and confirmed sexual violence.

Scenario 5:
A father brings his "delinquent son" to the health facility whom he reported of being stubborn and was a problem to the community. The boy had sustained a cut-wound after stealing a neighbour's sugarcane. The cut-wound required suturing. When the health worker interacted with the boy, he revealed that he had been recurrently sodomised by the father.

In addition to the former, children's counselling and communication process involves;

- Establishing a helping relationship with them
- Helping them tell their story (how, where, when and who)

Children raise issues they want to communicate with others but find it difficult to discuss directly. Children enjoy and communicate their emotional state by ***use of pictures and drawings*** *without having to put it into words and it's a powerful technique for use in child counselling. They also* ***use story-telling*** *and* ***use role play/acting*** *to express their feelings about events and make sense of the events.*

- Listening attentively to them
- Use simple language they are comfortable with
- Giving them correct and appropriate information
- Helping them make decisions to build on their strength
- Helping them develop a positive attitude towards life

Similarly don't

- Make decisions on their behalf
- Judge them
- Interrogate them
- Blame them
- Preacher lecture to them
- Make promises you cannot keep
- Impose your own beliefs on them
- Argue with them

MODULE 4
CLINICAL MANAGEMENT OF SEXUAL AND GENDER BASED VIOLENCE AND VIOLENCE AGAINST CHILDREN SURVIVORS/VICTIMS

MODULE DESCRIPTION

This module introduces the concept of clinical management of S/GBV and VAC survivors/victims.

It emphasizes the importance of respecting human rights while handling survivors/victims It includes detailed guidance on the clinical management of women, men and children who have been sexually abused. It explains how to take history, perform a thorough physical examination, record the findings and give medical care to someone who has been sexually abused.

The module highlights the concept of identifying survivors/victims subjected to sexual gender based violence/violence against children in all clients/patients seeking health services at all levels of Health care delivery. This is because/violence especially sexual gender based violence/violence against children has for long been recognized as a public health concern and significantly affects health outcomes. However health care systems often miss this very important health determinant. Routine screening for S/GBV and VAC survivor's/victim's therefore improves sexual and reproductive health-related diagnosis, treatment, counselling and follow up.

Health workers should have a high suspicion index so as to ask people/clients who visit the health units about experiences of violence whether or not they have any signs and symptoms.

NOTE:

The health care provider's responsibility is to provide appropriate care, to record the details of the history, the physical examination, and other relevant information, and, with the person's consent, to collect any forensic evidence that might be needed in a subsequent investigation. It is not the responsibility of the health care provider to determine whether a person has been raped/defiled/sexually assaulted. However, he/she has a responsibility to help the survivor/Victim seek legal assistance if the survivor/Victim so wishes. That is a legal determination.

It is only the court of law which can determine legally if a survivor/Victim was raped/defiled and not the health worker. **Health workers should avoid using statements with legal connotation e.g. rape, defilement etc.**

This module will include the following sessions

1. Identification of a survivor/victim of gender based violence/Violence against Children.
2. Preparations to offer medical care to S/GBV and VAC survivors/victims
3. Preparing the survivor/victim for the examinations
4. Taking the history
5. Documenting injuries and collecting forensic evidence
6. Performing the physical and genital examinations
7. Treatment and use of management protocols
8. Counselling after clinical care
9. Follow-up care of the survivor/Victim

SESSION 4.1: IDENTIFICATION OF A SURVIVOR/VICTIM OF GENDER BASED VIOLENCE/ VIOLENCE AGAINST CHILDREN

Session objectives

By the end of this session participants will be able to:

1. Discuss the manifestations (signs and symptoms) of a survivor/victim of S/GBV and VAC.
2. Discuss the importance of identifying S/GBV and VAC victims/survivor's/victim's in health facilities.
3. Discuss the steps to take if you suspect violence

Introduction

Identifying victims of SGBV/VAC in health care setting may be challenging as some victims may present with no obvious signs and symptoms. The person may not tell you about the violence due to shame or fear of being judged or fear of their partner reactions and actions. Such victims may be under threat from the perpetrators not to disclose incidences of torture. Its therefore important that while dealing with clients in health facilities, active effort should be made to look out for clients who maybe experiencing emotional or physical conditions, including injuries.

Manifestations of a survivor/victim of S/GBV and VAC (signs and symptoms)

You may suspect that a person has been subjected to violence if she/he has any of the following:

- Ongoing emotional health issues, such as stress, anxiety or depression
- Harmful behaviours such as misuse of alcohol or drug
- Thoughts, plans or acts of self-harm or (attempted) suicide
- Night mares, trouble sleeping, or fear of the dark
- Injuries that are repeated or not well explained
- Repeated sexually transmitted infections
- Unwanted pregnancies
- Unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches)
- Repeated health consultations with no clear diagnosis.
- Parents/adolescents seeking abortion/post-abortion services.
- Discontinuation of family planning method.
    - In addition to the above, Child survivors/victims may exhibit: declining performances and participation in class;
    - withdrawal from usual social activities such as plying with peers;

  - may exhibit more aggression;
  - engage in sexual behaviour that is inappropriate for their age;
  - bed wetting in children that had already outgrown the behaviour;
  - clinging to caregivers;
  - hyperactivity or inactivity; and
- Refusal to talk or to eat.

NOTE:

- Health workers should look out for manifestations that may appear among close family members especially children of the survivor/Victim for instance showing signs of neglect/torture e.g. malnutrition, multiple injuries.
- Men/spouses/ may also present with injuries caused by survivors/victims (female spouse)
- Men/boys also suffer injuries caused by S/GBV (they may be survivors/victims).

You may also suspect a problem of violence if a woman's partner or husband and Child's caretaker is intrusive during consultations.

Importance of identifying a survivor/victim of S/GBV and VAC

1. S/GBV and VAC is a major public health problem and a cause of a number of health issues like STIs/HIV, unwanted or unintended pregnancies, pregnancy related complications, abortions, psychosocial problems, physical injuries, disability and death among others.
2. S/GBV and VAC may result into social-economic problems that affect health such as discontinuation from a job, restricted movement, and lack of control over resources.
3. It helps providers understand the underlying causes behind many health conditions and thus provide the necessary counselling and health care eventually improving the health of survivors/victims.
4. It helps providers identify survivors/victims early before the violence escalates.
5. It helps save time and other resources for a number of women since the ones who are abused tend to visit health centres more often than other women.
6. Many survivor/Victim s may never disclose the fact that they experience violence for different reasons.
7. Some survivors/victims of S/GBV and VAC may have signs of violence and yet these maybe over looked by providers.
8. Early identification of violence can be a transforming and therapeutic experience as it empowers individuals to know their rights and also help them recover.
9. Health care providers are uniquely placed to identify survivors/victims and help them find other referral services.

MOH recommends health-care providers to conduct a clinical screening for SGBV and VAC among clients who have injuries or conditions/signs and symptoms that they suspect may be related to violence.

Steps to take if you suspect violence

Never raise the issue of violence in the presence of a suspected perpetrator even if they are family members or caregivers.

If you ask about violence, do it in an empathetic and non-judgemental manner. Use language that is appropriate and relevant to the culture and community you are working in. Some survivor's/victim's/ victims may not like the words "violence" and "abuse". Cultures and communities have ways of referring to the problem with other words. It is important to use the words that survivors/victims themselves use.

Below are some examples of the type of statements and questions you can use to ask about S/GBV/Intimate Partner Violence/violence against children.

- "Many individuals experience problems with their husband or partner, or someone else/care takers they live with."
- "I have seen people with problems like yours who have been experiencing trouble at home."
- We often see people experiencing problems in their relationships that can negatively affect their health and wellbeing.
- I have seen children like you who have been experiencing problems at home.

Here are some simple and direct questions that you can start with that show you want to hear about survivor/victim problems. Depending on the answers, continue to ask questions and listen to the story.

NOTE: Some of these tasks can be rephrased to address survivors/victims.

- "Has your husband (or partner) or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has it happened?"
- Do you feel afraid of this person?
- "Does your husband (or partner) or someone at home bully you or insult you?
- "Does your husband (or partner)/someone else try to control you, for example not letting you have money or go out of the house?"
- "Has your husband (or partner)/someone else forced you into sex or forced you to have any sexual contact you did not want?"
- "Has your husband (or partner) threatened to kill you?"

  If she answers "yes" to any of these questions, open up a file, document and offer her first-line support.

Documenting violence

Documenting is important to providing ongoing sensitive care, to remind yourself or to alert another provider at later visits. Documentation of injuries could be important if the survivor/victim decides to go to the police.

- Tell the Survivor/victim what you would like to write down and why. Ask her/him if this is okay. Follow his/her wishes if there is anything she/he does not want written down, do not record it.
- Enter in the medical record any health complaints, symptoms, and signs, as you would for any other person, including a description of her/his injuries. It is helpful to note the cause or suspected cause of these injuries or other conditions, including who injured her/him.
- Do not write anything where it can be seen by those who do not need to know, for example on an X-ray slip or a bed chart.
- Be aware of situations where confidentiality may be broken. Be cautious about what you write where and where you leave the records.
- For greater confidentiality, some facilities use a code or special mark to indicate cases of abuse or suspected abuse.

First-line support for the SURVIVORS/VICTIMS of violence

What is first-line support

First-line support is the package of services given to survivor's/victim's to respond to their immediate survivors/victims emotional, physical, safety and support needs, without intruding on their privacy.

Often, first-line support is the most important care that you can provide. Even if this is all you can do, you will have greatly helped your client. First-line support has helped people who have been through various upsetting or stressful events, including women subjected to violence.

Remember: This may be your only opportunity to help this client. The kind of first line support you offer the client greatly impacts on their healing and recovery.

First-line support involves 5 simple tasks. It responds to both emotional and practical needs at the same time. The letters in the word "LIVES" can remind you of these 5 tasks that protect client's lives:

LISTEN	Listen to the client closely, with empathy, and without judging.
INQUIRE ABOUT NEEDS AND CONCERNS	Assess and respond to various needs and concerns – emotional, physical, social and practical (e.g. childcare)
VALIDATE	Show that you understand and believe her/him. Assure her/him that s/he is not to blame.
ENHANCE SAFETY	Discuss a plan to protect the survivor/victim from further harm if violence occurs again.
SUPPORT	Support by helping her/him connect to information services and social support.

First-line support care for emotional needs

First-line support may be the most important care that you can provide, and it may be all that s/he needs. First-line support care is a combination of emotional and practical needs of a survivor/victim.

Its goals include:

- Identifying survivor's/victim's needs and concerns
- Listening and validating survivor's/victim's concerns and experiences
- Helping survivor/victim to feel connected to others, calm and hopeful
- Empowering survivor/victim to feel able to help him/herself.
- Exploring what survivor's/victim's options are
- Respecting her/his wishes
- Helping survivor/victim to find social, physical and emotional support
- Enhancing safety.

Remember: When you help survivor/victim **deal with their practical needs, it helps with** their **emotional needs.**

When you help with their emotional needs, you strengthen their ability to deal with practical needs.

You do <u>not</u> need to:

- Solve their problems
- Convince them to leave a violent relationship
- Convince them to go to any other services, such as police or the courts
- Ask detailed questions that force them r to relive painful events

• Ask them to analyse what happened or why
• Pressure them to tell you her feelings and reactions to an event

These actions could do more harm than good.

Tips for managing the conversation

- Choose a private place to talk, where no one can overhear (but not a place that indicates to others why you are there).
- Assure him/her that you will not repeat what she says to anyone else and you will not mention that she was there to anyone who doesn't need to know. If you are required to report her situation, explain what you must report and to whom.
- First, encourage him/her to talk and show that you are listening.
- Encourage him/her to continue talking if he/she wishes, but do not force him/her to talk. ("Do you want to say more about that?")
- Allow silences. If she cries, give her time to recover.

Remember: Always respect her wishes.

How to identify a survivor/victim experiencing violence

1. Assess your health unit's physical and human resources
2. Sensitise colleagues on the importance of identifying a survivor/victim of S/GBV and VAC
3. Use the tool to identifying a survivor/victim of woman/man who has injuries or conditions that they suspect may be related to violence.
4. Document, analyse and use the information

S/GBV and VAC SAMPLE SCREENING TOOL

1.1 **Have you ever felt harmed emotionally or psychologically by someone?** (Examples: constant insults, humiliation, destruction of objects you cared about, ridicule, rejection, isolation)			
Yes=1	No=2	Doesn't know=3	Doesn't answer=4

1.2 If YES: By whom were you harmed?															
Partner		Ex-partner		Parent		Step parent		Uncle/aunt/ sibling		Other relative		Other known person		Stranger	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F

1.3 If YES: When did this happen?			
Weeks ago	Months ago	Years ago	Doesn't know/Didn't answer

2.1 **Has any one ever harmed you physically?** (examples: hitting, slapping, burning, kicking, biting, pushing)			
Yes=1	No=2	Doesn't know=3	Doesn't answer=4

2.2 If YES: By whom were you harmed?															
Partner		Ex-partner		Parent		Stepparent		Uncle/aunt/ sibling		Other relative		Other known person		Stranger	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F

2.3 If YES: When did this happen?			
Weeks ago	Months ago	Years ago	Doesn't know/ Didn't answer

3.1 **Have you ever been touched, fondled in appropriately, or forced to have sexual contact or intercourse?**			
Yes=1	No=2	Doesn't know=3	Doesn't answer=4

3.2 If YES: By whom?															
Partner		Ex-partner		Parent		Step parent		Uncle/aunt/ sibling		Other relative		Other known person		Stranger	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F

3.3 If YES: When did this happen?			
Weeks ago	Months ago	Years ago	Doesn't know/ Didn't answer

4.1 **When you were a child, were you ever touched in an inappropriate way by anyone?**			
Yes=1	No=2	Doesn't know=3	Doesn't answer=4

4.2 If YES: By whom?											
Parent		Step parent		Uncle/aunt/ sibling		Other relative		Other known person		Stranger	
M	F	M	F	M	F	M	F	M	F	M	F

4.3 If YES: When did this happen?			
Weeks ago	Months ago	Years ago	Doesn't know/Didn't answer

5.1**Are you afraid of your partner or anyone else close to you?**		
Yes	No	Doesn't know

6.1**Will you be safe when you return home?**		
Yes	No	Doesn't know

7.1**Chart notes: Did you offer the client help?**			
Yes, and client accepted a referral to our psychosocial services		Yes, and client accepted a referral to other psychosocial services (shelter: counselling	
Yes, and client accepted a referral to our medical/surgical services (specify)		Yes, but client did not accept a referral	
		No, did not offer client help.	
Yes, and client accepted a referral to the police		Yes, and client accepted a referral to other police station	
Yes, and client accepted a referral to our legal services		Yes, and client accepted a referral to other legal services	
Yes, and the client accepted admission			
		Yes, and client accepted referral to secure accommodation (religious leaders, cultural leaders, relatives, significant others)	

Codes for perpetrators

Category of perpetrator	**Partner**	**Ex-partner**	**Parent**	**Step parent**	**Uncle Aunt/**	**Other relative**	**Other known**	**Stranger**
Male	M1	M2	M3	M4	M5	M6	M7	M8
Female	F1	F2	F3	F4	F5	F6	F7	F8

When this information is collected:

1. Use it to improve the quality of care provided to the client.
2. Use it in your health management information systems to improve your services.
3. Ensure safety of the client
4. Plan for follow up and/or referral to other services.

NB: Keep the information confidential

Subsequent visit:

On subsequent visits determine whether the risk is still present or not and plan for follow up care and/or referral.

What to do if you suspect violence, but the client doesn't disclose it

- Do not pressure the client, and give her/him time to decide what she/he wants to tell you.
- Tell client about services that are available if she/he chooses to use them.
- Offer information on the effects of violence on client's health and their children's health.
- Offer a follow-up visit.

SESSION 4.2: PREPARATIONS TO OFFER MEDICAL CARE TO S/GBV/ VAC SURVIVORS/VICTIMS

Session objectives

By the end of this session, participants will be able to:

1. Explain the requirements for management of S/GBV/ VAC SURVIVOR
2. Describe the different types of S/GBV and VAC services/care provided at different levels of health facilities and community
3. Discuss who should provide S/GBV and VAC medical services.

INTRODUCTION

The health care service provider must make preparations to respond thoroughly and compassionately to people who have been sexually abused. The District Health Office should ensure that health care providers are trained to provide appropriate care and have the necessary equipment and supplies.

In setting up a service, the following questions and issues need to be addressed, and standard procedures developed.

Health care workers will manage S/GBV and VAC cases according to their competences and level of health facility as shown below.

Where should care be provided?

Generally, a clinic or out patient service that already offers reproductive health services, such as family planning, antenatal care, normal delivery care or management of STIs can offer care for S/GBV and VAC survivor/Victim s. Some services may need referral to a hospital.

Who should provide care?

All staff in health facilities dealing with S/GBV and VAC survivor/Victim s, from reception staff to health care professionals, who are sensitized and trained according to their needs and service areas. They should always be compassionate and respect confidentiality. *(Refer to the tables below.*

How should care be provided?

Care should be provided:

- According to the provided protocols. Protocols include guidance on medical, psychosocial and ethical aspects, on collection and preservation of forensic evidence, and on counselling and psychological support options;
- In comprehensive, confidential and non-judgmental manner; with a focus on the survivor/Victim and her/his needs; with an understanding of the provider's own attitudes and sensitivities, the socio-cultural context, and the community's perspectives, practices and beliefs.

What is needed?

- All health care for S/GBV survivor/Victim s should be provided in one place within the health care facility so that the person does not have to move from place to place.
- Services should be available 24 hours a day, 7 days a week.
- All available supplies from the checklist should be prepared and kept in a special box or place, so that they are readily available. (see checklist)

How to coordinate with others

- Inter-agency and inter-sectorial coordination should be established to ensure comprehensive care for survivor/Victim s of violence.
- Be sure to include representatives of social and community service protection, the police or legal justice system, and security. Depending on the services available in the particular setting, others may need to be included.
- As a multi-sectorial team, establish referral networks, communication systems, coordination mechanisms, and follow-up strategies.

Health facilities:

High quality facilities for providing medical services to S/GBV and VAC survivors/victims are characterized by a number of key features. They should be accessible, secure, clean and private. All of these features should be incorporated when planning a new facility or modifying an existing facility.

The location:

The ideal location for a health care facility for S/GBV and VACsurvivors/victims is either within a hospital or a medical clinic, or where there is immediate access to medical expertise. For instance, a patient may present with acute health problems (e.g. head injury, intoxication) that require urgent medical intervention and treatment. Similarly, there should be ready access to a range of laboratory (e.g. haematology, microbiology) and counselling services.

Basic facility requirements for managing survivors/victims of sexual and gender based violence and violence against children.

FEATURE	NOTES AND COMMENTS
Accessibility	24-hour access to service providers is preferable.
Security	At both individual and community level, there may be some antagonism to sexual assault services. There should therefore be adequate measures to protect patients, staff, health records and the facility itself. Strategies could include the use of a guard to control access, adequate lighting, lockable doors and cabinets, fire prevention equipment and video-surveillance.
Cleanliness	A high standard of hygiene is required in the provision of any Medical service. The facility should also comply with local safety and health regulations as they apply to fire, electricity, water, sewerage, ventilation, sterilization and waste disposal.
Privacy	Unauthorised people should not be able to view or hear any aspects of the consultation. Hence, the examination room(s) should have walls and a door, not merely curtains. Perpetrators must be kept separate from their victims.

In terms of accommodation, there should be at least two rooms: a waiting room/reception plus a separate consulting/examination room (preferably with access to toilet.) Additional room(s) for others (e.g. family, friends, and police) would be useful. If the facility is providing services to children, the physical surroundings should be child-friendly and special equipment for interviewing the child (e.g. two-way mirrors or video-recording facilities) may be required.

THE IDEAL FACILITY

NOTE:

It is recognized that very few places will be in a position to provide and enjoy the ideal facility. However this should not deter provision of S/GBV and VAC services.

An examination room should be equipped with the following:

- An examination couch positioned so that the health worker can approach the patient from the right-hand side; the couch must allow examination with the legs flopped apart (i.e. in the lithotomy position);
- Thermally neutral (i.e. not too cold or too hot);
- Auditory and visual privacy (particularly for undressing);
  - Clean bed-linen and a gown for each patient;
  - Lighting sufficient to perform a genito-anal examination;
  - Hand-washing facilities (with soap and running water);
  - Forensic supplies;

- A table or desk for documenting and labelling specimens;
- A lockable door to prevent entry during the examination;
- A telephone

- A separate room containing a table and chairs where a support person could talk with the patient, and facilities for offering patients refreshments and a change of clothing and also for children who may be attending as patients or accompanying an adult.
- Shower and toilet for the patient.
- A room for the police.
- A counselling room
- A reception area that could also be used as a waiting room for family and friends.

CHECKLIST OF NEEDS FOR CLINICAL MANAGEMENT OF S/GBV and VAC SURVIVORS/VICTIMS.

1. **Standard operating procedures Available**
   - Written medical job aide , IEC/BCC charts and Referral Pathway in language of provider if necessary
2. **Personnel**
   - Trained health care professionals (on call 24 hours/day)
   - For female survivor/Victim s, a female health care provider speaking the same language is optimal. If this is not possible, a female health worker or companion should be in the room during the examination
3. **Furniture/Setting**
   - Room (private, quiet, accessible, with access to a toilet or latrine)
   - Examination table
   - Light, preferably fixed (a torch may be threatening for children)
   - Magnifying glass (or colposcope)
   - Access to an autoclave to sterilise equipment
   - Access to laboratory facilities/microscope/trained technician
   - Weighing scales and height chart for children
4. **Supplies**

   A Sexual Assault Kit for collection of forensic evidence, could include:
   - Speculum(preferably plastic, disposable, only adult sizes)
   - Comb for collecting foreign matter in pubic hair
   - Syringes/needles (Butterfly needles for children)/tubes for collecting blood
   - Glass slides for preparing wet and/or dry mounts (for sperm)
   - Cotton-tipped swabs/applicators/gauze compresses for collecting samples
   - Laboratory containers for transporting swabs
   - Paper sheet for collecting debris as the survivor/Victim undresses

- Tape measure for measuring the size of bruises, lacerations, etc.
- Paper bags for collecting of evidence materials
- Paper tape for sealing and labelling containers/bags
- Supplies for universal precautions (gloves, waste-bins for safe disposal of contaminated and sharp materials, soap and water)

Other supplies

- Resuscitation equipment
- Sterile medical instruments (kit)for repair of tears, and suture material
- Needles, syringes
- Cover (gown, cloth, and sheet) to cover the survivor/Victim during the examination.
- Spare items of clothing to replace those that are both torn or taken for evidence.
- Sanitary supplies (pads or local cloths)
- Pregnancy tests
- Pregnancy calculator to determine the age of a pregnancy

5. Medicines

- For treatment of STIs as per country protocol
- For post-exposure prophylaxis of HIV transmission (PEP)
- Emergency contraceptive pills and/or copper-bearing intrauterine device (IUD)
- Tetanus toxoid, tetanus immunoglobulin
- Hepatitis B vaccine
- For pain relief(e.g. paracetamol)
- Anxiolytic (e.g. diazepam)
- Local anaesthetic for suturing
- Medicines for wound care

6. Administrative Supplies

- Medical chart with pictograms
- Forms for recording post-rape care
- Consent forms
- Information pamphlets for post-rape (for survivor/victim)
- Safe, locked filing space to keep records confidential
- Referral forms

S/GBV SERVICES AVAILABILITY BY LEVEL OF CARE

Type of service	Facility					
	Community	Outreach	HCII-III	HCIV	General hospital	Referral hospital
IEC	use ticks					
Psychosocial support and counselling						
History taking						
Examination						
HIV serology						
High vaginal swab						
Semen analysis						
DNA testing of various tissues						
PEP						
Emergency contraception						
STI management						
Anti-tetanus toxoid						
Surgical interventions						
Rehabilitation						
First Aid						
Referral to other services						
Post-mortem						

Tips for carrying out successful management of S/GBV and VAC survivors/victims

1. Identify a team of professionals and community members who are involved or should be involved in caring for people who have been sexually abused.
2. Create a referral network between the different sectors involved in caring for S/GBV and VACsurvivors/victims that is to say community, health, security, protection.
3. Identify the available resources (drugs, materials, laboratory facilities), M and E TOOLS and the relevant national laws, policies and procedures relating to violence e.g. sexual abuse (standard treatment protocols, legal procedures, laws relating to abortion, etc.) *See relevant annexes.*
4. Train providers to use the protocol, including what must be documented during an examination for legal purposes.

S/GBV SERVICE PROVISION BY HEALTH WORKERS' CATEGORY

Type of service	Cadre									
	VHTmember	Nursing Assistant	Midwife/Nurse	Clinical officer	Medical officer	Specialist	Physiotherapist	Radiologist	Lab Tech/ Cytologist	Social worker
IEC	□use	□	□	□	□	□	□	□	□	□
Psychosocial support and counselling	□ticks	□	□	□	□	□	□	□	□	□
History taking	□	□	□	□	□	□	□	□		□
Examination			□	□	□	□	□	□		
HIV serology		□	□	□	□	□	□	□	□	
High vaginal swab			□	□	□	□			□	
Semen analysis									□	
DNA testing of various tissues									□	
PEP			□	□	□	□				
Emergency contraception	□	□	□	□	□	□	□	□	□	□
STI management	□	□	□	□	□	□				
Anti-tetanus toxoid		□	□	□	□	□				
Surgical interventions			□	□	□	□				
Rehabilitation	□	□	□	□	□	□	□	□	□	□
First Aid	□	□	□	□	□	□	□	□	□	□
Referral	□	□	□	□	□	□	□	□	□	□
Post-mortem					□	□				

There may be S/GBV and VAC survivors/victims who may request for termination of pregnancy, it should only be performed on medical grounds as provided for by the constitution of Uganda.

SESSION 4.3: PREPARING THE SURVIVOR/VICTIM FOR THE EXAMINATION

Session objectives

By the end of this session, the participants should be able to:

1. Explain the purpose of preparing the survivor/victim before the examination.
2. Describe how to prepare the S/GBV/ VAC survivor/victim for examination.

INTRODUCTION

A person who has been sexually abused, has experienced trauma and may be in an agitated or depressed state. S/he often feels fear, guilt, shame and anger or any combination of these. The health worker must prepare her/his and obtain her informed consent for the examination, and carry out the examination in a compassionate, systematic and complete fashion.

HOW TO PREPARE THE SURVIVOR/VICTIM FOR THE EXAMINATION

- Ensure that a trained health professional of the same sex is with the survivor/victim throughout the examination.
- Explain what is going to happen during each step of the examination, why the step is important, what it will tell you and how it will influence the care you are going to give.
- Reassure the survivor/victim that s/he is in control of the pace, timing and components of the examination. Reassure the survivor/victim that the examination findings will be kept confidential unless s/he decides to bring charges.
- Ask her/him if s/he has any questions.
- Ask if s/he wants to have a specific person present for support. Ask her this when s/he is alone.
- Review the consent form with the survivor/victim. Make sure s/he understands everything in it and explain that s/he can refuse any aspect of the examination s/he does not wish to undergo. Once you are sure s/he understands the form completely ask her to sign it. If s/he cannot write, obtain a thumb print together with the signature of a witness. *(see annex 2)*
- Limit the number of people allowed in the room during the examination to the minimum necessary. **(At least not more than 3)**
- Do the examination as soon as possible.
- Do not force or pressure the survivor/victim to do anything against her/his will.
- Explain that s/he can refuse steps of the examination at any time as it progresses.

PREPARING A CHILD FOR EXAMINATION

A parent or legal guardian should sign the consent form for examination of the child and collection of forensic evidence, unless s/he is the suspected offender. In this case, **a representative** from the police, the community support services or the court may sign the form. Adolescents may be able to give consent themselves.

The child should never be examined against his/her will, whatever the age, unless the examination is necessary for medical care and in the best interest of the child.

The initial assessment may reveal severe medical complications that need to be treated urgently, and for which the patient will have to be admitted to hospital. Such complications include:

- Convulsions;
- Persistent vomiting;
- Stridor in a calm child;
- Lethargy or unconsciousness;
- Inability to drink or breastfeed.

In children younger than 3 months, look also for:

- Fever;
- Low body temperature;
- Bulging fontanels;
- Grunting, chest in-drawing and a breathing rate of more than 60 breaths/minute.

The treatment of these complications is not covered in detail here, however when identified, use the standard management guidelines to manage them.

CREATE A SAFE ENVIRONMENT

- Take special care in determining who is present during the interview and examination (remember that it is possible that a family member is the perpetrator of the abuse). It is preferable to have the parent or guardian wait outside during the interview and have an independent trusted person present. For the examination, either a parent or guardian or a trusted person should be present. Always ask the child who s/he would like to be present, and respect his/her wishes. Bigger children tend to feel shy to open up in the presence of other people especially their parents/guardians. Sometimes, these may be the perpetrators or supporters of the perpetrators and this will hinder obtaining the correct information.
- Introduce yourself to the child.
- Sit at eye level and maintain eye contact.
- Assure the child that s/he is not in any trouble.
- Ask a few questions about neutral topics, e.g., school, friends, who the child lives

with, favourite activities, etc.

- When examining a child, there should be a support person or trained health worker whom the child trusts in the examination room with you.
- Encourage the child to ask questions about anything s/he is concerned about or does not understand at any time during the examination.
- Explain what will happen during the examination, using terms the child can understand.
- With adequate preparation, most children will be able to relax and participate in the examination.
- It is possible that the child cannot relax because s/he has **pain**. If this is a possibility, give paracetamol or other simple pain killers, and wait for them to take effect.
- Never restrain or force a frightened, resistant child to complete an examination. Restraint and force are often part of sexual abuse and, if used by those attempting to help, will increase the child's fear and anxiety and worsen the psychological impact of the abuse.
- It is useful to have a doll on hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.

SESSION 4.4: TAKING HISTORY

Session objectives

By the end of this session participants will be able to:

1. Explain the general guidelines followed when taking history from an S/GBV and VAC survivor/victim.
2. Discuss the general information to be recorded.
3. Demonstrate ability to take proper history (risk of pregnancy and STI or HIV).

GENERAL GUIDELINES

- Introduce yourself and the interpreter where applicable.
- If the interview is conducted in the treatment room, cover the medical instruments until they are needed.
- Take history before reviewing any documents or paper work brought by the survivor/Victim to the health centre.
- Use a calm tone and maintain eye contact in a culturally appropriate manner.
- Develop a culturally responsive environment that is not stigmatizing and discriminative
- Explain to the survivor/Victim that you are going to record the relevant history and explain the purpose of doing so e.g. that it may be useful if seeking for legal redress.
- Guide the survivor/victim to tell his/her story the way s/he wants to and record it in his/her own words.
- You may need to rephrase and paraphrase in order to clarify some parts of his/her story.
- Questioning should be done gently and at the survivor/Victim 's own pace. Avoid questions that suggest blame such as "*what were you doing there alone?*"
- Take sufficient time to collect all needed information, without rushing.
- Avoid any distraction or interruption during the history-taking.
- Explain what you are going to do at every step.

A sample history and examination form is included in Annex 3 & 4. The main elements of relevant history are described below.

General information

- Particulars of the survivor/victim: name, age, last normal menstrual period (LNMP)
- Name, district, village, phone(s), sex, date of birth (or age in years).
- Date and time of the examination and the names and function of any staff or support person (someone the survivor/victim may request) present during the interview and examination.

Description of the incident

- Do not press her/him to explain what s/he does not feel comfortable with but explain that such questions may be asked in court.
- Reassure her/him of confidentiality if s/he is reluctant to give detailed information.
- Ask the survivor/victim to describe what happened. Allow her/him to speak at her/his own pace. Do not interrupt to ask for details; follow up with clarification questions after s/he finishes telling her/his story.
- Survivor/Victim s may omit or avoid describing details of the assault that are particularly painful or traumatic, but it is important that the health **worker understands exactly what happened** in order to check for possible injuries and to assess the risk of pregnancy and STI/HIV.

Note the following:

- If the incident occurred recently, determine whether the survivor/victim has bathed, urinated, defecated, vomited, used a vaginal douche or changed clothes since the incident. *This may determine what forensic evidence to be collected.*
- Information on existing health problems: mental, sensually or physical disabilities, allergies, use of medication, and vaccination and HIV status will help you to determine the most appropriate treatment to provide, necessary counselling and follow-up health care.
- Evaluate for possible pregnancy; ask for details of contraceptive use and date of **last menstrual period.**

Some survivors/victims of sexual violence have been found to be pregnant at the time of the examination. Some were not aware of their pregnancy. Explore the possibility of a pre-existing pregnancy in women of reproductive age by a pregnancy test or by history and examination. The following checklist suggests useful questions to ask the survivor/Victim if a pregnancy test is not possible.

Checklist for pre-existing pregnancy		
No	**Important Questions**	**Yes**
	Have you had your normal Menstrual Period within the last 4 weeks?	
	Have you given birth in the past 4 weeks?	
	Are you less than 6 months postpartum **and** exclusively breastfeeding **and** free from menstrual bleeding since you had your child?	
	Have you had a miscarriage or abortion in the past 7 days?	
	Have you gone without sexual intercourse since your last menstrual period?	
	Have you been using a reliable contraceptive method consistently and correctly? *(check with specific family planning method)*	

If the survivor/victim answers **NO** to all the questions, ask about and look for signs and symptoms of pregnancy. If pregnancy *cannot* be ruled out or confirmed provide her with information on emergency contraception to help her arrive at an informed choice on emergency contraception.

If the survivor/victim answers **YES** to at least 1 question and she is free of signs and symptoms of pregnancy, provide her with information on emergency contraception to help her arrive at an informed choice on Emergency contraception.

HISTORY TAKING OF THE CHILD

- For children who are unable to speak for themselves, history may be taken from parent/guardian/caregiver/third-party (always indicate with a hysteric information obtained from a person other than the survivor/victim).
- Begin the interview by asking open-ended questions, such as "Do you know why you are here today?" Or "What happened?"
- Avoid asking leading or suggestive questions.
- Assure the child it is okay to respond to any questions with "I don't know".
- Be patient; go at the child's pace; do not interrupt his or her train of thought.
- Ask open-ended questions to get information about the incident. Ask yes/no questions only for clarification of details.
- For girls, depending on age, ask about menstrual and obstetric history.

The pattern of sexual abuse of children is generally different from that of adults. For example, there is often repeated abuse. To get a clearer picture of what happened, try to obtain information on:

- The home situation (has the child a secure place to go to?);
- How the rape/abuse was discovered;
- Who did it, and whether s/he is still a threat;
- If this has happened before, how many times and the date of the last incident;
- Whether there have been any physical complaints (e.g. bleeding, dysuria, discharge, difficulty walking, etc.);
- Whether any siblings or other persons are at risk.
- Whether any other person is aware about the sexual abuse.

SESSION 4.5: PERFORMING THE PHYSICAL AND GENITAL EXAMINATION

Session objectives

By the end of this session participants must be able to:

1. Discuss general guidelines that should be followed when performing physical and genital examination
2. Explain the steps taken while conducting a physical examination for the S/GBV and VAC survivor/victim
3. Discuss the steps taken while conducting genital, anal and rectal examinations
4. Explain the steps taken while performing physical examination for particular categories of people
5. Explain how to document physical and genital injuries
6. Demonstrate ability to perform physical and genital examination

PHYSICAL EXAMINATION

The primary objective of the physical examination is to determine whether the violence occurred and what medical care should be provided to the survivor/Victim. Work systematically according to the medical examination form *(see sample form-Annex 3)*.

What is included in the physical examination will depend on how soon the survivor/Victim presents after the violence. Follow the steps in Part A if s/he presents within 72 hours of the incident; Part B is applicable to survivor/Victims who present more than 72 hours after the incident. The general guidelines apply in both cases.

General guidelines

- Make sure the equipment and supplies are prepared.
- ***Always look at the survivor/Victim first, before you touch him/her,*** and note his/her appearance and mental state.
- ***Always tell him/her what you are going to do and ask him/her permission before you do it.***
- Assure him/her that s/he is in control, can ask questions, and can stop the examination at any time.
- Take the patient's vital signs (pulse, blood pressure, respiratory rate and temperature).
- The initial assessment may reveal severe medical complications that need to be treated urgently and for which the patient will have to be admitted to hospital. Such complications might include:
    1. Extensive trauma (to genital region, head, chest or abdomen), fractures etc
    2. Asymmetric swelling of joints (septic arthritis),

3. Neurological deficits,
4. Respiratory distress.

The treatment of these complications is as per the national treatment guidelines.

- Obtain voluntary informed consent for the examination and obtain the required samples for forensic examination (see sample consent form in Annex 2).

Record all your findings and observations as clearly and completely as possible on a standard History and examination form (see Annex 3).

STEPS TAKEN WHILE CONDUCTING A PHYSICAL EXAMINATION FOR S/GBV and VAC SURVIVORS/VICTIMS:

The steps will depend on whether the survivor/Victim comes within 72 hours of the incident or after 72 hours of the incident

Scenario 1: If Survivor/Victim presents within 72 hours of the incident

Physical examination

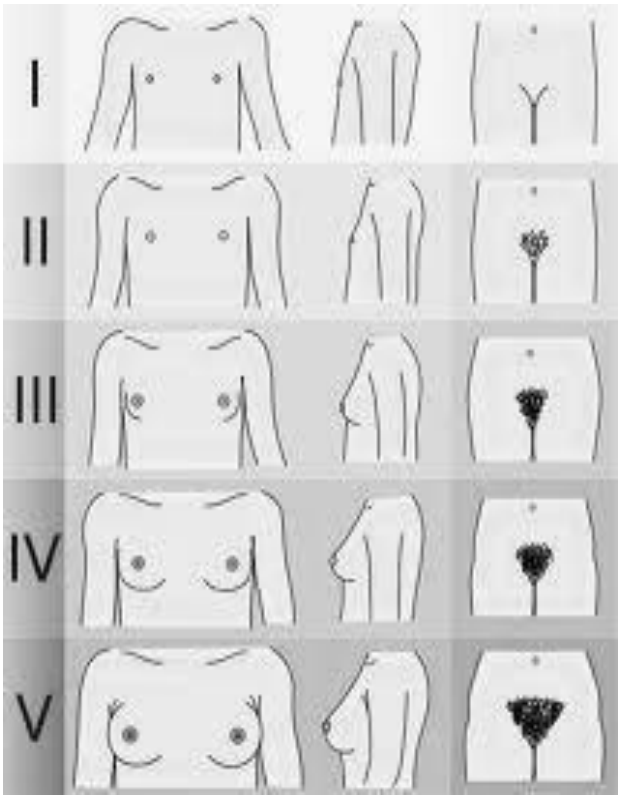
- Never ask the survivor/Victim to undress or uncover completely. Examine the upper half of his/her body first, then the lower half; or give her/him a gown to cover him/herself.
- Minutely and systematically examine the patient's body. Start the examination with vital signs, hands and wrists rather than the head, since this is more reassuring for the survivor/Victim. Do not forget to look in the eyes, nose and mouth (inner aspects of lips, gums and palate, in and behind the ears and on the neck. Check for signs of pregnancy.

When managing pre-and adolescents, children, it is important to use the Tanner Staging to estimate the developmental stage as shown below.

The tanner stages

Because the onset and progression of puberty are so variable, Tanner has proposed a scale, now uniformly accepted, to describe the onset and progression of pubertal changes. Boys and girls are rated on a 5 point scale. Boys are rated for genital development and pubic hair growth, while girls are rated for breast development and pubic hair growth. See figure below.

The stages in female and male pubic hair, penis, and breast development are as follows:



Pic.A

Pic.B

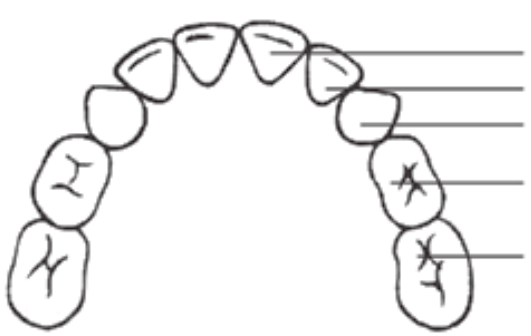
TANNER STAGING SCHEDULE

Stage	FEMALES				MALES				
	Age range (years)	Breast growth	Pubic hair growth	Other changes	Age range (years)	Testes growth	Penis growth	Pubic hair growth	Other changes
I	0–15	Pre-adolescent	None	Pre-adolescent	0–15	Pre-adolescent testes (≤2.5 cm)	Pre-adolescent	None	Pre-adolescent
II	8–15	Breast budding (thelarche); areolar hyperplasia with small amount of breast tissue	Long downy pubic hair near the labia, often appearing with breast budding or several weeks or months later	Peak growth velocity often occurs soon after stage II	10–15	Enlargement of testes; pigmentation of scrotal sac	Minimal or no enlargement	Long downy hair, often appearing several months after testicular growth; variable pattern noted with pubarche	Not applicable
III	10–15	Further enlargement of breast tissue and areola, with no separation of their contours	Increase in amount and pigmentation of hair	Menarche occurs in 2% of girls late in stage III	1½–16.5	Further enlargement	Significant enlargement, especially in diameter	Increase in amount; curling	Not applicable
IV	10–17	Separation of contours; areola and nipple form secondary mound above breasts tissue	Adult in type but not in distribution	Menarche occurs in most girls in stage IV, 1–3 years after thelarch	Variable: 12–17	Further enlargement	Further enlargement, especially in diameter	Adult in type but not in distribution	Development of axillary hair and some facial hair
V	12.5–18	Large breast with single contour	Adult in distribution	Menarche occurs in 10% of girls in stage V.	13–18	Adult in size	Adult in size	Adult in distribution (medial aspects of thighs; linea alba)	Body hair continues to grow and muscles continue to increase in size for several months to years; 20% of boys reach peak growth velocity during this period

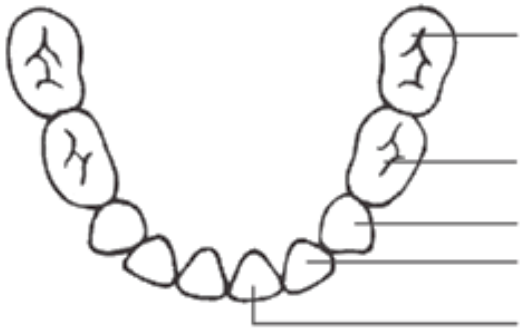
Source: www.ncbi.nlm.nih.gov/book/n/whoartch/#annex.n218

Teeth Eruption schedule with Age range Estimation

Primary Teeth

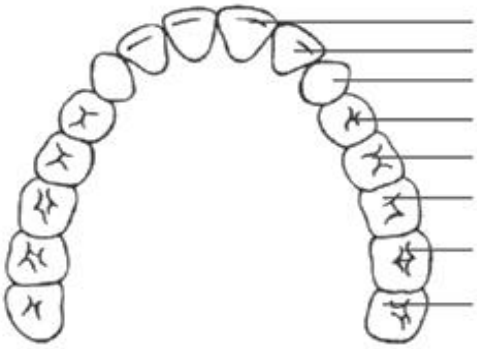


Upper Teeth	Erupt	Shed
Central incisor	8–12 mos.	6–7 yrs.
Lateral incisor	9–13 mos.	7–8 yrs.
Canine (cuspid)	16–22 mos.	10–12 yrs.
First molar	13–19 mos.	9–11 yrs.
Second molar	25–33 mos.	10–12 yrs.

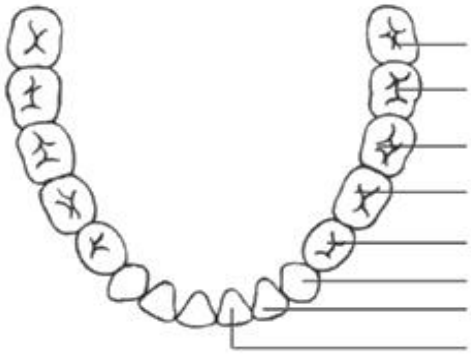


Lower Teeth	Erupt	Shed
Second molar	23–31 mos.	10–12 yrs.
First molar	14–18 mos.	9–11 yrs.
Canine (cuspid)	17–23 mos.	9–12 yrs.
Lateral incisor	10–16 mos.	7–8 yrs.
Central incisor	6–10 mos.	6–7 yrs.

Permanent Teeth



Upper Teeth	Erupt
Central incisor	7–8 yrs.
Lateral incisor	8–9 yrs.
Canine (cuspid)	11–12 yrs.
First premolar (first bicuspid)	10–11 yrs.
Second premolar (second bicuspid)	10–12 yrs.
First molar	6–7 yrs.
Second molar	12–13 yrs.
Third molar (wisdom tooth)	17–21 yrs.



Lower Teeth	Erupt
Third molar (wisdom tooth)	17–21 yrs.
Second molar	11–13 yrs.
First molar	6–7 yrs.
Second premolar (second bicuspid)	11–12 yrs.
First premolar (first bicuspid)	10–12 yrs.
Canine (cuspid)	9–10 yrs.
Lateral incisor	7–8 yrs.
Central incisor	6–7 yrs.

- Look for signs that are consistent with the survivor/victim's story, such as bite and punch marks, marks of restraints on the wrists, patches of hair missing from the head, or torn ear drums, which may be a result of being slapped. If the survivor/Victim reports being throttled, look in the eyes for petechial haemorrhages.

  Examine the body area that was in contact with the surface on which the violation occurred to see if there are injuries or anything unusual.
- Note all your findings carefully on the examination form and the body figure pictograms (see Annex 5), taking care to record the type, size, colour and form of any injuries e.g. bruises, lacerations, ecchymonthsis and petechial.
- Take note of the survivor/Victim mental and emotional state (withdrawn, crying, calm, etc.)
- Take samples of any foreign material on the survivor/Victim body or clothes (blood, saliva, and semen), finger nail cuttings or scrapings, swabs of bite marks, etc.

EXAMINATION OF THE GENITAL AREA, ANUS AND RECTUM

Do genito-anal examination

In cases of sexual assault, a genito-anal examination is necessary. This is a sensitive examination, particularly the speculum exam.

- Help the survivor/victim feel as comfortable as possible.
- Let her/him know when and where you will touch.
- Help the survivor/victim to lie on her/his back with legs bent, knees comfortably apart.
- Place a sheet over her/his body. It should be drawn up at the time of the examination.
- Work systematically. Have a good light source to view injuries.
- Record all your findings and observations clearly and fully on a standard exam form.

> **Remember:** Being sexually assaulted is a traumatic event.
> Survivor/victim may be very sensitive to being examined or touched, particularly by an opposite-sex provider. Proceed slowly. Ask often if s/he is okay and if you can proceed.
> ***There is no place for virginity (or 'two-finger') testing; it has no scientific validity. Be very careful not to increase her distress.***

Even when female genitalia are examined immediately after a violation, there is identifiable damage in less than 50% of cases. Carry out a genital examination as indicated below. **Collect evidence as you go along; according to the evidence collection protocol** *(see Annex 6)*. Note the location of any tears, abrasions and bruises on the pictogram and the examination form.

- Systematically inspect, in the following order, the mons pubis, inside of the thighs, perineum, anus, labia majora and minora, clitoris, urethra, introitus and hymen: Note any scars from previous female genital mutilation or childbirth.
- Look for genital injury, such as bruises, scratches, abrasions, tears (often located on the posterior couchette).
- Look for any sign of infection, such as ulcers, pus discharge or warts.
- Check for injuries to the introitus and hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Hymenal tears are more common in children and adolescents.
- Take samples according to the evidence collection protocol. When collecting samples for DNA analysis, take swabs from around the anus and perineum before the vulva in order to avoid contamination.
- For the anal examination the patient may have to be in a different position than for the genital examination. Write down her position during each examination (supine, prone, knee-chest or lateral recumbent for anal examination; supine for genital examination).
- Note the shape and dilatation of the anus. Note any fissures around the anus, the presence of faecal matter on the perianal skin and bleeding from rectal tears.
- If indicated by the history, collect samples from the rectum according to the evidence collection protocol.
- If there has been vaginal penetration, gently insert a speculum, lubricated with water or normal saline (do not use a speculum when examining children)
- Under good lighting inspect the cervix, then the posterior fornix and the vaginal mucosa for trauma, bleeding and signs of infection.
- Take swabs and collect vaginal secretions according to the evidence collection protocol.
- If indicated by the history and the rest of the examination, do a bimanual examination and palpate the cervix, uterus and adnexa, looking for signs of abdominal trauma (like tenderness, guarding) pregnancy or infection.
- If indicated, do a recto vaginal examination and inspect the rectal area for trauma, recto-vaginal tears or fistula, bleeding and discharge. Note the sphincter tone. If there is bleeding, pain or suspected presence of a foreign object, refer the patient to a hospital/level of care where she/he can be managed.

Scenario 2: If Survivor/Victim presents more than 72 hours after the incident

Physical examination

It is rare to find any physical evidence more than one week after an assault. If the survivor/victim presents within a week of the rape, or presents with complaints, do a full physical examination as above. In all cases:

- Note the size and colour of any bruises and scars;
- Note any evidence of possible complications of the sexual assault (deafness,

fractures, abscesses, etc.);

- Check for signs of pregnancy;
- Note the survivor/victim's mental state (normal, withdrawn, depressed, and suicidal).

Examination of the genital area

If the assault occurred more than 72 hours but less than a week ago, note any healing injuries to genitalia and/or recent scars. If the assault occurred more than a week ago and there are no bruises or lacerations and no complaints (e.g. of vaginal or anal discharge or ulcers), there is little indication to do a pelvic examination.

Even when one might not expect to find injuries, the survivor/victim might feel that she has been injured

NOTE:

1. A careful inspection with subsequent reassurance that no physical harm has been done may be of great relief and benefit to the patient and might be the main reason she is seeking care.
2. It is unacceptable to penetrate the vagina of a woman who is a virgin with anything, including a speculum, finger or swab. In this case you may have to limit the examination to inspection of the external genitalia, unless there are symptoms of internal damage.

SPECIAL CONSIDERATIONS FOR ELDERLY WOMEN

Elderly women who have been sexually assaulted are at increased risk of vaginal tears and injury and transmission of STI and HIV. Decreased hormonal levels following the menopause result in reduced vaginal lubrication and are thinner and more friable vaginal wall. Use a thin speculum for genital examination. If the only reason for the examination is to collect evidence or to screen for STIs, consider inserting swabs only without using a speculum.

SPECIAL CONSIDERATIONS FOR MEN

- For the genital examination:
- Examine the penis (prepuce, periurethral tissue, urethral meatus, and corona), scrotum and testicles.
- Examine the anus for any abnormal discharge, growth, ulcers sphincter tone and fissures.
- Note if the survivor/Victim has been circumcised.
- Look for glans penis, hyperaemia, swelling (distinguish between inguinal hernia, hydrocele and haematocele), torsion of testis, bruising, anal tears, etc.
- Torsion of the testis is an emergency and requires immediate surgical referral.

- If the urine contains large amounts of blood, check for penile and urethral trauma.
- If indicated, do a rectal examination and check the rectum and prostate for trauma and signs of infection.
- If relevant, collect material from the anus for direct examination for sperm under a microscope.

CONDUCTING THE EXAMINATION IN CHILDREN

Conduct the examination in the same order as an examination for adults. Special considerations for children are as follows:

- Note the child's weight, height and pubertal stage. Ask girls whether they have started menstruating. If so, they may be at risk of pregnancy.
- Small children can be examined on the mother's lap. Older children should be offered the choice of sitting on a chair or on the mother's lap, or lying on the bed. Check the hymen by holding the labia at the posterior edge between index finger and thumb and **gently p**ulling outwards and downwards. Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymenal tissue and the size of the vaginal orifice are not sensitive indicators of penetration.
- Do **not** carry out a digital examination (i.e. inserting fingers into the vaginal orifice).
- Look for vaginal discharge. In pre-pubertal girls, vaginal specimens can be collected with a dry sterile cotton swab.
- Do not use a speculum to examine pre-pubertal girls; it is extremely painful and may cause serious injury. In case it is needed, use a small size speculum.
- A speculum may be used **only** when you suspect a penetrating vaginal injury and internal bleeding. **In this case, a speculum examination of a pre-pubertal child is usually done under general anaesthesia**. Depending on the setting, the child may need to be referred to a higher level of health care.
- In boys, check for injuries to the frenulum of the prepuce, and for anal or urethral discharge; take swabs if indicated.
- All children, boys and girls, should have an anal examination as well as the genital examination. Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as perpetrators often use it.
- Record the position of any anal fissures or tears on the pictogram.
- Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.
- Do **not** carry out a digital examination to assess anal sphincter tone. (Manual anal dilatation contraindicated in children).

If the child is highly agitated

In rare cases, a child cannot be examined because s/he is highly agitated. Only if the child cannot be calmed down and physical treatment is vital, the examination may be performed with the child under sedation, using drugs such as:

- diazepam, by mouth, 0.15 mg/kg of body weight; maximum 5mg
- promethazine hydrochloride, syrup, by mouth; 1mg/kg (maximum 12.5mg) orally0.5mg/kg (maximum 12.5mg) rectal
- Melatonin, 3-6mg orally (for children 6 months and below the primary care-giver should be supported to soothe the infant.)

In case the weight of the child cannot be obtained, for 2 – 5 years give 12.5mg while for 5 – 10 years give 20 – 25 mg

NOTE:

These drugs do not provide pain relief. If you think the child is in pain, **give simple pain relief first**, such as paracetamol (<1 year give 10mg/kg body weight; 1-5 years: 120-250mg; 6-12 years: 250-500mg) or rectal paracetamol250mg or any other analgesic like diclofenac as per the national treatment guidelines. Wait for this to take effect.

Oral sedation will take 1-2 hours for full effect. In the meantime allow the child to rest in a quiet environment.

LABORATORY TESTING

Only the samples mentioned in *Session 4.5* need to be collected for laboratory testing. If indicated by the history or the findings on examination, further samples may be collected for medical purposes.

Tests to be conducted include;

- Pregnancy test, if indicated (see Session 4.3).
- Samples may be taken from the vagina, anus, mouth and penis for STI screening for treatment purposes.

Screening might cover:

- Rapid plasma reagin (RPR)test for syphilis or any point-of-care rapid test
- Gram stain and culture for bacteria e.g. gonococco
- Culture or enzyme-linked immuno sorbent assay(ELISA) for Chlamydia or any point-of care rapid test;
- Wet mount for Trichomonus vaginalis
- HIV test (only on a voluntary basis and after counselling).
- If the survivor/Victim has complaints that indicate a urinary tract infection, collect a urine sample to test for erythrocytes and leukocytes, and for possible culture.
- Other diagnostic tests, such as X-ray and ultrasound examinations, may be useful in diagnosing fractures and abdominal trauma.

Laboratory testing in children

Testing for sexually transmitted infections should be done on a case-by-case basis and is strongly indicated in the following situations:

- the child presents with signs or symptoms of STI;
- the suspected offender is known to have an STI or is at high risk of STI;
- there is a high prevalence of STI in the community;
- the child or parent requests testing.

In some settings, screening for gonorrhoea, chlamydia, syphilis and HIV is done for all children who may have been sexually abused. The presence of any one of these infections may be diagnostic of rape (if the infection is not likely to have been acquired during pregnancy or child birth (perinatally) or through blood transfusion). Follow your local protocol.

NB: A health worker faced with the victim of S/GBV and VAC must priotise the collection and documentation of forensic evidence since this is important when prosecuting these cases.

SESSION 4.6: DOCUMENTING INJURIES AND COLLECTING FORENSIC EVIDENCE

Session objectives

By the end of this session, the participants should be able to:

1. Define forensic evidence.
2. Explain the reasons for documenting injuries and forensic evidence findings.
3. Discuss how to accurately document injuries suffered by survivor/victims and collect the relevant forensic evidence.
4. List samples that can be collected as evidence
5. Discuss how to present medical evidence in court.
6. Discuss the importance of making a medical certificate and what it includes.
7. Demonstrate ability to collect, Document, package, transport, store and examine forensic evidence

INTRODUCTION

The main purpose of the examination of a survivor/victim is to determine whether or not an assault took place and what medical care or possible legal redress can be provided. Forensic evidence should be collected to help the survivor/victim pursue legal redress.

The survivor/Victim may choose not to have forensic evidence collected. Respect his/her choice. However the survivor/victims should be given adequate information regarding the relevance of collecting forensic evidence to enable them make informed decisions.

NOTE: Only qualified and trained health workers should collect evidence. Forensic evidence should be collected as soon as possible after the incidence.

Meaning of Forensic Evidence:

Forensic evidence is any biological or non-biological material which may be used in a legal case.

REASONS FOR COLLECTING EVIDENCE

- A forensic examination aims at establishing whether or not a sexual assault took place and collecting forensic evidence that may help prove or disprove a connection between individuals and/or objects or places.
- Forensic evidence may be used to support a survivor/Victim's story, to confirm recent sexual contact, to show that force or coercion was used and possibly to identify the attacker.

Annex 5 provides pictograms for forensic examination and documentation.

Annex 6 is a list of relevant reagents, equipment, supplies for laboratory service for S/GBV and VAC.

Documenting injuries and collecting samples, such as blood, hair, saliva and sperm, within 72 hours of the incident may help to support the survivor/Victim's story and might help identify the aggressor(s). If the person presents more than 72 hours after the sexual assaults the amount and type of evidence that can be collected will depend on the situation.

Whenever possible, forensic evidence should be collected during the medical examination so that the survivor/Victim is not required to undergo multiple examinations which might be invasive and may prove traumatic.

DOCUMENTING THE CASE

- Record the interview and your findings of the examination in a clear, complete, objective and non-judgmental way.

NOTE: The interview and findings must be recorded in the clinical notes. Enter the information in the History and Examination Forms for GBV/vac. Fill the Police Form 3, 3A, 24, 24A if they are available and keep a copy of the police form. This is confidential information and should be kept under lock and key in the health facility.

- Document your findings objectively. Note that in some cases of sexual assaults there may not be any significant clinical findings.
- Completely assess and document the physical and emotional state of the survivor/Victim.
- Document all injuries clearly and systematically using standard terminology and describing the characteristics of the wounds *(see Table below)*. Record your findings on pictograms (see Annex 5).
- Record precisely, in the survivor/Victim's own words, important statements made by him/her, such as reports of threats made by the perpetrator. Do not be afraid to include the name of the perpetrator, but use qualifying statements, such as "survivor/victim states or reports".
- Avoid the use of the term "alleged", as it can be interpreted as meaning that the survivor/Victim exaggerated or lied.
- Make note of any sample collected as evidence

DESCRIBING FEATURES OF WOUNDS

Features	Notes
Classification	Use accepted terminology wherever possible i.e. abrasion, contusion, laceration, incised wound, gun shot, cut wound.
Site	Record the anatomical position of the wound(s)
Size	Measure the dimension of the wound(s)
Shape	Describe the shape of the wound(s) (e.g. linear, curved, and
Surrounding	Note the condition of the surrounding or nearby tissues (e.g. bruised, swollen.)
Colour	Observation of colour is particularly relevant when describing bruises, burns.
Course	Comment on apparent direction of force applied (e.g. in abrasions)
Contents	Note the presence of any foreign material in the wound (e.g. dirt, grass, glass, blood, fluids)
Age	Comment on any evidence of healing. (Note that it is impossible to accurately identify the age of an injury and great caution is required when commenting on this aspect.
Borders	The characteristics of the edges of the wound(s) may provide a clue as to the weapon used.
Depth	Give an indication of the depth of the wound(s) this may have to be an estimate.

Adapted from Guidelines for micro-legal care for victims of sexual violence, Geneva, WHO, 2003.

SAMPLES THAT CAN BE COLLECTED AS EVIDENCE

- Some samples and materials e.g. clothing, hair, foreign material, should be collected in liaison with the Police or scene-of-crime officers. This also includes blood or urine which may be collected for toxicology testing (e.g. if the survivor/Victim was drugged).

Clothing: torn or stained clothing may be useful to prove that physical force was used. If clothing cannot be collected (e.g. if replacement clothing is not available) describe its condition.

- Foreign material (soil, leaves, and grass) on clothes or body or in hair may corroborate the survivor/Victim's story and this should be collected using drop-sheet technique.
- Hair: foreign hairs may be found on the survivor/Victim's clothes or body. Pubic and head hair from the survivor/Victim may be plucked or cut for comparison.
- Sperm and seminal fluid: swabs may be taken from the vagina, anus or oral cavity, if penetration took place in these locations, to look for the presence of Sperm and for prostatic acid phosphatase analysis.
- Blood: Hepatitis B, HIV (serology, DNA-PCR, ELISA)
- Urine: Urinalysis to rule out STIs and Pregnancy
- High Vaginal Swab: Semen analysis, Gram stain to rule out STI due to bacteria,

parasites and fungi.

- DNA analysis, where available, can be done on material found on the survivor/Victim's body or at the location of the sexual abuse, which might be soiled with blood, sperm, saliva or other material from the perpetrator (e.g. clothing, sanitary pads, handkerchiefs, condoms), as well as on swab samples from bite marks, semen stains and involved orifices and on finger nail cuttings and scrapings. In this case, blood from the survivor/Victim must be drawn to allow his/her DNA to be distinguished from any foreign DNA found.

  Note: Always take control of samples i.e. from the survivor/Victim and the perpetrator

- Vaginal fluids from corona or glans penis for DNA by swabs

Forensic evidence should be collected during the medical examination and should be stored in a confidential and secure manner. The consent of the survivor/Victim must be obtained before evidence is collected. Work systematically according to the medical examination form (see Annex 3). Explain everything you do and why you are doing it. Evidence should only be released to the authorities if the survivor/Victim decides to proceed with a case.

- All samples should be clearly labelled with the survivor/victim's name, nature of sample, date and time of collection, and name of the health personnel.
- If any officer needs to take the collected evidence for more processing, s/he should sign to acknowledge receipt in either a delivery book or the survivor/victim's examination and history form.
- Document the findings on the S/GBV and VAC medical certificate under section of "Other examinations carried out and samples taken".

All the above tests are done following the routine laboratory procedures and standard operating procedures (SOPs).

The capacity of laboratories to analyse forensic evidence differs considerably. This annex 3 describes the different types of forensic evidence that can be collected. Health workers should familiarise themselves with national and local protocols and resources. Collect what can be processed in the unit or kept properly/safely for future use.

INSPECTION OF THE BODY

- Examine the survivor/victim's clothing under a good light before s/he undresses. Collect any foreign debris on clothes and skin or in the hair (soil, leaves, grass, and foreign hairs). Ask the person to undress while standing on a sheet of paper to collect any debris that falls. Do not ask her/him to uncover fully. Examine the upper half of the body first, then the lower half, or provide a gown for her/him to cover her/himself. Collect torn and stained items of clothing only if you can give her/him replacement clothes.
- Document all injuries in detail as much as possible
- Collect samples for DNA analysis from all places where there could be saliva (where the attacker licked or kissed or bit) or semen on the skin, with the aid of a sterile cotton-lipped swab, lightly moistened with sterile water if the skin is dry.
- The survivor/Victim's pubic hair may be combed for foreign hairs.
- If ejaculation took place in the mouth, take samples and swab the oral cavity for direct examination for spermatozoa and for DNA and acid phosphatase analysis. Place a dry swab in the spaces between the teeth and between the teeth and gums of the lower jaw, as semen tends to collect there.
- Take blood and/or urine for toxicology if indicated (e.g. if the survivor/Victim was drugged).

INSPECTION OF THE ANUS, PERINEUM, PENIS AND VULVA

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

EXAMINATION OF THE VAGINA AND RECTUM

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

- Lubricate a speculum with normal saline or clean water (other lubricants may interfere with forensic analysis)
- Using a cotton-tipped swab, collect fluid from the posterior fornix for sperm examination. Put a drop of the fluid collected on a slide (if necessary with a drop of normal saline -wet-mount) and examine for sperm under a microscope. Note the mobility of any sperm. Smear the leftover fluid on a second slide and air-dry both slides for further examination at a later stage.

NOTE:

After 72 hours the spermatozoa may lose the tail but will still be visible under the microscope

- Using separate cotton-tipped swabs, take specimens from the posterior fornix and the endo-cervical canal for DNA analysis. Let them dry at room temperature.

- Collect separate samples from the cervix and the vagina for acid phosphatase analysis for confirmation of presence of semen.
- Obtain samples from the rectum, if indicated, for examination for sperm, DNA profiling and acid phosphatase analysis.

MAINTAINING THE CHAIN OF EVIDENCE

Maintaining the chain of evidence refers to how samples are collected, labelled, stored and transported properly without being distorted or damaged. It also takes care of tracking who is safely keeping (taking custody) of the collected samples and materials from the survivor/Victim up to the time they are presented in court.

It is important to maintain the chain of evidence at all times, to ensure that the evidence will be admissible in court. Documentation must include a signature of everyone who has possession of the evidence at any one time, from the individual who collects it to the one who takes it to the courtroom.

If it is not possible to take the samples immediately to a laboratory, the following precautions must be taken:

- All cloths, swabs, gauze and other objects to be analysed need to be air-dried at room temperature and packed in paper (not plastic/polythene) bags. Samples can be tested for DNA many years after the incident, provided the material is well dried.
- Blood and urine samples can be stored in the refrigerator for not more than 5 days. To keep the samples longer they need to be stored in a freezer. Follow the instructions of the local laboratory.
- All samples should clearly be labelled with a confidential identifying code (not the name nor initials of the survivor/Victim), date, time of collection, and type of sample, what it is, from where it was taken and put in a recommended container.
- Seal the bag or container with paper tape across the closure, with the identifying codes. Put the date and sign your initials across the tape.

In the adapted protocol, clearly write down the laboratory's instructions for collection, storage and transportation of samples.

Note: Evidence should be released to the authorities only if the survivor/victim decides to proceed with a legal care.

The survivor/victim at the time of the examination may consent to have evidence collected but not to have it released to the authorities. In this case, advise her/him that the evidence will be kept in a secure locked place in the health facility. If s/he changes her/his mind during this period, s/he can advise the authorities where to find the collected evidence.

REPORTING MEDICAL FINDINGS IN A COURT OF LAW

If the survivor/Victim wishes to pursue legal redress and the case comes to trial, the health worker who examined him/her after the incident may be asked to report on the findings in the courts of law. Many health workers may be anxious about appearing in court or feel that they do not have enough time to do this. However, health workers should know that providing such evidence is their responsibility.

In cases of **rape**, the prosecutor (not the health care provider) must prove three things:

1. Some penetration, however slight of the vagina or anus by a penis or other object, or penetration of the mouth by a penis.
2. That penetration occurred without the consent of the person.
3. The identity of the perpetrator.

In most settings, the health care provider is expected to give evidence as a factual witness (that means restating the findings as s/he recorded them), not as an expert witness.

PREPARING FOR A COURT SESSION

The health worker should meet with the prosecutor prior to the court session to prepare her/his testimony and obtain information about the significant issues involved in the case.

- Prepare decent/appropriate dressing for the courtroom.
- Avoid consumption of drugs and alcohol prior to the court session.
- Revise your medical report to refresh your memory before you go court and carry a copy along with you
- Prepare to be in court at least 30 minutes before court starts

While in court;

- Always address your responses to the presiding officer (judge/magistrate) using their appropriate titles as follows;
  - Judge - "My lord"
  - Magistrate - "Your Worship"
- Conduct yourself professionally and confidently.
- Introduce yourself fully, including your current duty station and all qualifications, relevant training, skills and experience if asked
- Speak clearly and slowly and, if culturally appropriate, make eye contact with whoever you are speaking to
- Use precise medical terminology and remember not to contradict the findings in your medical report
- Answer questions as thoroughly and professionally as possible

- If you do not know the answer to a question, say so. Do not make up an answer and do not testify about matters that are outside your area of expertise
- Ask for clarification of questions that you do not understand. Do not try to guess the meaning of questions

NOTE: Refer to session 2.4 "the relevance of medical evidence in prosecution of S/GBV and VAC cases" under the section "procedure for producing medical evidence in court".

- The notes written during the initial interview and examination are the mainstay of the findings to be reported. It is difficult to remember things that are not written down. This underscores the need to record all statements, procedures and actions in sufficient detail, accurately, completely and legibly. This is the best preparation for an appearance in court.
- Always record your finding immediately after the examination before anything is forgotten.

THE MEDICAL CERTIFICATE

Medical care of a survivor/victim of sexual assault includes preparing a medical certificate. This is a legal requirement. It is the responsibility of the health care provider who examines the survivor/victim to make sure such a certificate is completed.

The medical certificate is a confidential medical document that the recommended health worker must hand over to the survivor/victim. The medical certificate constitutes an element of proof and is often the only material evidence available, apart from the survivor/victim's own story.

The health care provider should keep one copy locked away with the survivor/victim's file, in order to be able to certify the authenticity of the document supplied by the survivor/victim before a court, if requested. The survivor/victim has the sole right to decide whether and when to use this document.

The medical certificate may be handed over to legal services or to organizations with a protection mandate only with the explicit agreement of the survivor/victim.

(See Annex 7for examples of medical certificates). These should be adapted to each setting in consultation with a legal expert.

A medical certificate must include:

- The name and signature of the examiner;
- The name of the survivor/Victim ;
- The exact date and time of the examination;
- The survivor/victim's narrative of the sexual assault, in her/his own words;
- The findings of the clinical examination;

- The nature of the samples taken;
  - *If the certificate is more than one page, these elements should be included on every page of the document.*

If the certificate is shared with human rights organizations for advocacy purposes, without the consent of the survivor/victim, her/his name must be removed from every page.

Session 4.7: Treatment and Use of Management Protocols

SESSION OBJECTIVES

By the end of the session participants should be able to:

1. Explain the relevant investigations carried out during the management of S/GBV and VAC survivors/victims
2. Discuss management of STIs in survivors/victims of S/GBV and VAC
3. Explain steps followed in providing PEP for HIV
4. Discuss how to prevent unwanted pregnancy sing emergency contraceptives in survivor/Victim s of rape/defilement
5. Describe when to administer Tetanus Toxoid and Tetanus immunoglobulin in people with wounds due to sexual assault
6. Describe why and how to give hepatitis B vaccine to rape survivor/Victim s
7. Discuss the immediate mental health care given to support survivors/victims of sexual violence.

Introduction

Treatment will depend on how soon after the incident the survivor/victim presents to the health facility for services. Follow the steps in Part A if she presents within 72 hours of the incident; Part B is applicable to survivors/victims who present more than 72 hours after the incident. Male survivors/victims require the same vaccinations and STI treatment as female survivor/Victim.

Investigations carried out during the management of S/GBV and VAC survivors/victims

- Do a pregnancy test; if indicated and available (see session 3).
- Other diagnostic tests, such as X-ray and ultrasound examinations, may be useful in diagnosing fractures and abdominal trauma.
- Rapid plasma reagin(RPR)test for syphilis or any point-of-care rapid test;
- Gram stain and culture for gonorrhoea;
- Culture or enzyme-linked immunosorbent assay(ELISA) for Chlamydia or any point-of-care rapid test;
- Wet mount for trichomoniasis;
- HIV test (only on a voluntary basis and after counselling).

Investigations in children

Testing for sexually transmitted infections should be done on a case-by-case basis and is strongly indicated in the following situations:

- The child presents with signs or symptoms of STI;
- The suspected offender is known to have an STI or is at high risk of STI;
- There is a high prevalence of STI in the community;
- The child or parent requests testing.

Note: Samples may be taken from the vagina and anus for STI screening for treatment purposes. In some settings, screening for STIs and HIV is done for all children who may have been raped. The presence of any one of these infections may be diagnostic of sexual assault (if the infection is not likely to have been acquired perinatally or through blood transfusion). Follow your local protocol.

Scenario1: Survivor/Victim presents within 72 hours of the incident

Prevent sexually transmitted infections (*seeANNEX9*)

- Survivors/victims of sexual assault should be given antibiotics to treat gonorrhoea, chlamydial infection and syphilis according to the STI syndromic approach. If you know that other STIs are prevalent in the area (such as trichomoniasis or chancroid), give preventive treatment for these infections as well.
- Give the shortest courses available in the local protocol, which are easy to take. For instance: 400mg of cefixime single dose plus1g of azithromycin single dose orally will be sufficient presumptive treatment for gonorrhoea, chlamydial infection and syphilis.
- Be aware that women who are pregnant should not take antibiotics such as Tetracycline, Ciprofloxacin, etc. and modify the treatment, as per the STIs syndromic approach.
- Examples of WHO-recommended STI treatment regimens are given in *Annex 10* but use the STI syndromic approach guidelines in your health units.
- Preventive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV (PEP), although the doses should be spread out (and taken with food) to reduce side-effects, such as nausea.

Prevent HIV transmission (*See protocol ANNEX 10*)

Good to know before you develop your protocol

There is evidence that starting ARVs for PEP within 2-72 hours of exposure prevents the exposed person from developing overt AIDS disease. PEP for S/GBV and VAC survivors/victims is available in Uganda at Government hospitals, Health Centre IVs and some Health Centre IIIs that provide chronic HIV care. Before starting PEP service, it is

crucial that all staffs are aware of the indications for PEP and trained in counselling survivor/Victim s on PEP service provision. It is also important that a list of providers' names including psychosocial support providers and their addresses and telephone contacts are compiled and disseminated to key stakeholders.

- HCT is the gate way to provision of PEP services following any exposure. The survivor/victim should be given both pre-test and post-test counselling in preparation for PEP delivery. If the Survivor/Victim that decline HIV testing should not be given PEP because they may be already HIV positive. In that case, the PEP would not be beneficial to the individual.
- PEP is offered to all eligible (who come within 2 to 72hours) survivors/victims of sexual violence. It is very difficult to draw a line between low and high risk categories in sexual exposure, therefore all sexual exposures are considered to be high risk and warrant ARVs for PEP. However, it is important to note that HIV transmission is more likely to occur if there was penetration, there was more than one perpetrator; if the survivor/victim has tears of the vagina, penis or anus, if the perpetrator is known to be HIV-positive or an injection drug user.
- PEP in sexual exposure is a reserve for survivor/Victim s of sexual violence and not for casual/consensual sexual exposures. If a perpetrator is HIV negative while the survivor/victim is HIV positive refer to PEP policy.
- PEP for sexual exposures consists of 3 drug regimen antiretroviral (ARV) combination. (See Annex 11 for examples). ARVs for PEP should be taken for 28 days and any survivor/victim who declines to comply should not be given the service.
- If there are no PEP services in the facility, the health worker should refer the survivor/Victim as soon as possible (within 2-72 hours of exposure) to a health facility with PEP services. However, the survivor/victim should be provided with information on Voluntary Counselling and Testing (VCT) services that are available at the health facility.

PEP can be started on the same day as emergency contraception and preventive STI regimens. However, to increase drug compliancy and reduce side-effects, such as nausea, the various drugs should be spread out and taken with food.

Prevent pregnancy (*see protocol ANNEX11*)

- Taking emergency contraceptive pills (ECs) within 120 hours (5days) of unprotected intercourse will reduce the chance of a pregnancy by 56% to 93%, depending on the regimen and the timing of taking the medication.
- **Progesterone-only pills are the recommended EC regimen.** They are more effective than the combined oestrogen-p**rogesterone** regimen and have fewer side-effects (see Annex 12).
- Emergency contraceptive pills work by interrupting a woman's reproductive cycle by delaying or inhibiting ovulation, blocking fertilization or preventing implantation

of the ovum. ECs do not interrupt or damage an established pregnancy and thus WHO does not consider them a method of abortion.

- The use of emergency contraception is a personal choice that can only be made by the woman herself. Women should be offered objective counselling on this method so as to reach an informed decision. A health worker who is willing to prescribe ECs should always be available to prescribe them to sexual assault survivors/victims who wish to use them.
- If the survivor/victim is a child who has reached menarche, discuss emergency contraception with him/her and his/her parent or guardian, who can help him/her to understand and take the regimen as required.
- If an early pregnancy is detected at this stage, either with a pregnancy test or from the history and examination, make it clear to the woman that it is a result of the rape.
- There is no known contraindication to giving ECs at the same time as antibiotics for STIs and PEP, although the doses should be spread out and taken with food to reduce side-effects, such as nausea.

Provide 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.

Prevent tetanus

Good to know before you develop your protocol

- Tetanus toxoid is available in several different preparations. Check local vaccination guidelines for recommendations.
- The MOH immunization policy recommends vaccination of all women of childbearing age(15-45years) including pregnant women. The immunization schedule and interval is between doses as follows:
  - TT1 and TT2: 4 weeks
  - TT2 and TT3: 6 months
  - TT3 and TT4: one year
  - TT4 and TT5: one year

A dose of 0.5mls is given intramuscularly on the upper arm. In addition, TT is provided to infants in a combined formulation (pentavalent vaccine: DPTHepB+Hb). A dose of 0.5ml is given in 3 doses at 6,10 and14weeks on the outer upper thigh intramuscularly.

- Tetanus immunoglobulin (antitoxin) is expensive and needs to be refrigerated. It is not readily available. ,TT-tetanus toxoid; DTP-triple antigen: diphtheria and tetanus toxoids and pertussis; TIG–tetanus immunoglobulin

- If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the survivor/Victim has been fully vaccinated.
- Use Table 2 to decide whether to administer tetanus toxoid (which gives active protection) and tetanus immunoglobulin, if available (which gives passive protection).
- If vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and different sites of administration.
- Advise survivor/Victim s to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to1 year).

Guide for administration of tetanus toxoid and tetanus immunoglobulin to people with wounds.

History of tetanus immunization *(number of doses)*	**If wounds are clean and<6hours old or minor**		**All other wounds**	
	TT	**TIG**	**TT**	**TIG**
Uncertain 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

For children less than 7 years old, DPT (Pentavalent) or DT is preferred to tetanus toxoid alone. For persons 7 years and older, TIG is preferred to tetanus toxoid alone.

Prevent hepatitis B

Good to know before you develop your protocol

- Find out the prevalence of hepatitis B in your setting, as well as the vaccination schedules
- The prevalence of Hepatitis B in Uganda is 10.3%. The northern region has almost double the national prevalence with the highest prevalence of infection found among Karamojong.
- Hepatitis B is spread through contact with blood or other body fluids such as saliva, semen and vaginal fluid.
- The Hepatitis policy in Uganda recommends vaccination of all infants, 3 doses are recommended at 6, 10 and 14 weeks of age (dose 0.5ml). In addition, the MOH recommends vaccination of all health workers because they are at risk of exposure to infection in health care setting. 3 doses are recommended for adults at 0,1 and 6 month intervals.
- There is no information on the incidence of hepatitis B virus (HBV) infection following rape. However, HBV is present in semen and vaginal fluid and is efficiently transmitted by sexual intercourse. If possible, survivors/victims of sexual assault should receive hepatitis B vaccine within14 days of the incident.
- Give the vaccine by intramuscular injection in the deltoid muscle (adults) or the anterolateral thigh (infants and children). Do not inject into the buttock, because this is less effective.

- The vaccine is safe for pregnant women and for people who have chronic or previous HBV infection. It may be given at the same time as tetanus vaccine.

Provide mental health care

- Social and psychological supports, including counselling are essential components of medical care for the S/GBV and VAC survivor/victim. Most survivors/victims of sexual abuse will regain their psychological health through the emotional support and understanding of people they trust, community counsellors, and support groups. At this stage, do not push the survivor/victim to share personal experiences beyond what she wants to share. However, the survivor/victim may benefit from counselling at a later time, and all survivor/Victim s should be offered a referral to the community focal point for Sexual and Gender-Based Violence, if one exists.
- If the survivor/victim has symptoms of panic or anxiety, such as dizziness, shortness of breath, palpitations and choking sensations, that cannot be medically explained (i.e. without an organic cause), explain to her that these sensations are common in people who are very scared after having gone through a frightening experience, and that they are not due to disease or injury. The symptoms reflect the strong emotions she is experiencing, and will go away over time as the emotion decreases.
- Provide medication only in exceptional cases, when acute distress is so severe that it limits basic functioning, such as being able to talk to people, for at least24hours. In this case and only when the survivor/victim's physical state is stable, give a 5mg or 10mg tablet of diazepam, to be taken at bed time, no more than 3 days. Refer the person to a professional trained in mental health for reassessment of the symptoms the next day. If no such professional is available, and if the severe symptoms continue, the dose may be repeated for a few days with daily assessments.
- **Be very cautious: benzodiazepine use may quickly lead to dependence, especially among trauma survivor/Victim s.**

Many symptoms will disappear over time without medication, especially during the first few months. However, if the assault occurred less than 2 to 3 months ago and the survivor/Victim complains of sustained, severe subjective distress lasting at least 2 weeks, which is not improved by psychological counselling and support (seeStep7), and if she asks repeatedly for more intense treatment and you cannot refer her, consider a trial of Imipramine, Amitriptyline or similar anti-depressant medicine, up to 75-150mg at bedtime. Start by giving 25mg and if needed, work up to higher doses over a week or so until there is a response. Watch out for side-effects, such as a dry mouth, blurred vision, irregular heartbeat, and light-headedness or dizziness, especially when the person gets out of bed in the morning. The duration of the treatment will vary with the medication chosen and the response.

Scenario 2: Survivor/Victim presents more than 72 hours after the incident

Sexually transmitted infections

If laboratory screening for STIs reveals an infection, or if the person has symptoms of an STI, follow the STI Syndromic Approach Protocol.

HIV transmission

In some settings, testing for HIV can be done as early as six weeks after a sexual assault. Generally, however, it is recommended that the survivor/Victim is referred for voluntary counselling and testing (VCT) after 3-6 months, in order to avoid the need for repeated testing (ANNEX10)

Pregnancy

- If the survivor/victim is pregnant, try to ascertain if she could have become pregnant at the time of the assault. If she is, or may be pregnant as a result of the assault, counsel him/her on the possibilities available to him/her in your setting.

- If the survivor/victim presents between 72 hours (3 days) and within 120hours (5 days) after the rape, taking progestogen-only emergency contraceptive pills will reduce the chance of a pregnancy. The regimen is most effective if taken within 72hours, but it is still moderately effective within 120hours after unprotected intercourse (see Annex 9). There is no data on effectiveness of emergency contraception after 120 hours.
- If the survivor/Victim presents within five days of the rape, insertion of a copper-bearing IUD is an effective method of preventing pregnancy (it will prevent more than 99% of subsequent pregnancies). The IUD can be removed at the time of the woman's next menstrual period or left in place for future contraception. Women should be offered counselling on this service so as to reach an informed decision. A skilled provider should counsel the patient and insert the IUD. If an IUD is inserted, make sure to give full STI treatment to prevent infections of the upper genital tract.

Bruises, wounds and scars

Treat, or refer for treatment, all unhealed wounds, fractures, abscesses and other injuries and complications.

Tetanus

Tetanus usually has an incubation period of 3 to 21days, but it can be many months. Refer the survivor/victim to the appropriate level of care if you see signs of a tetanus infection. If she/he has not been fully vaccinated, vaccinate immediately, no matter how long it is since the incident. If there remain major, dirty, unhealed wounds, consider giving tetanus immunoglobulin if this is available.

Hepatitis B

Hepatitis B has an incubation period of 2-3 months on average. If you see signs of an acute infection, refer the person if possible or provide counselling. If the person has not been vaccinated and it is appropriate in your setting, vaccinate, no matter how long it is since the incident.

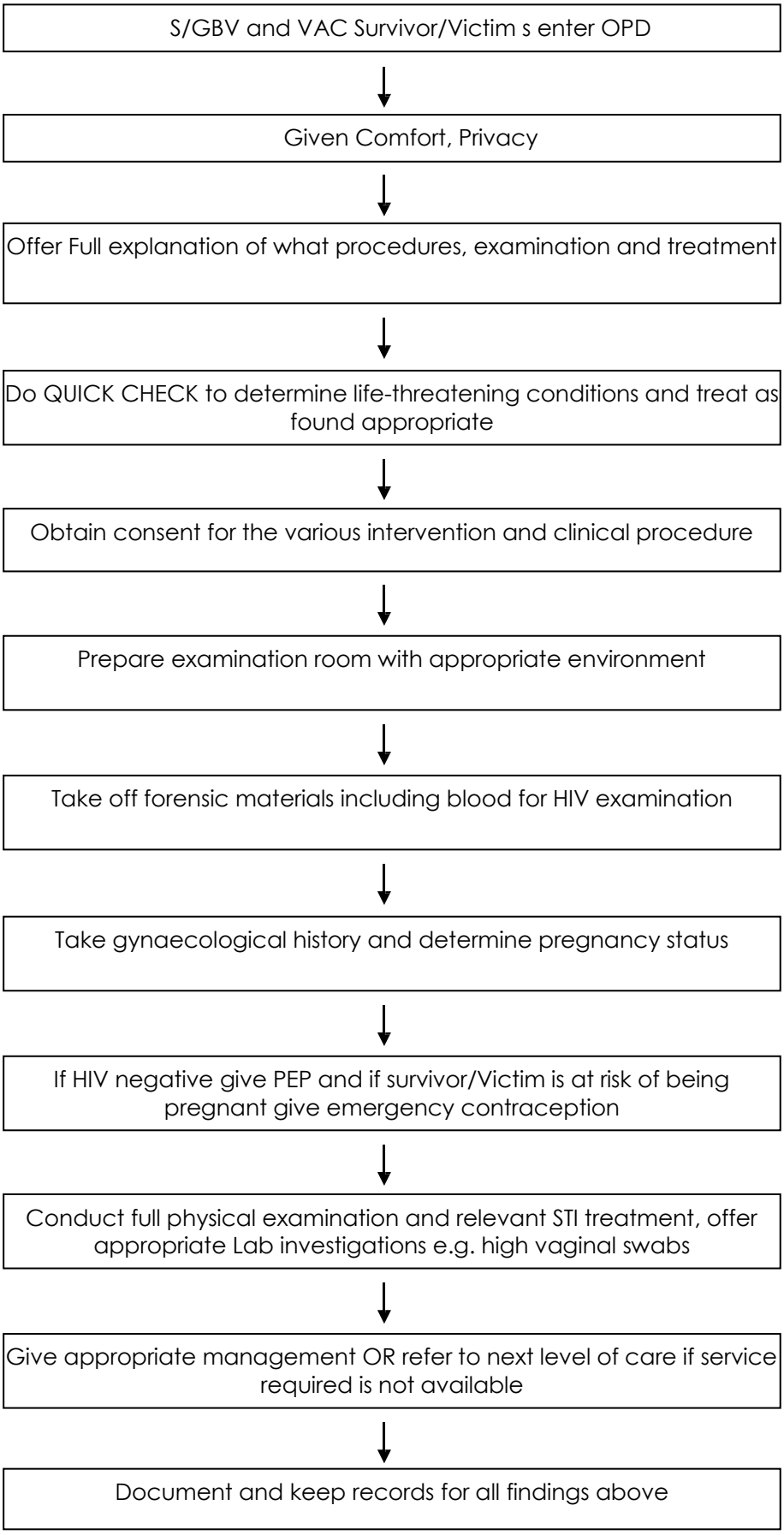
Mental health

- Social support and psychological counselling(see session 7) are essential components of medical care for the sexual assault survivor/victim. Most survivors/victims of sexual abuse will regain their psychological health through the emotional support and understanding of people they trust, community counsellors, and support groups. All survivors/victims should be offered a referral to the community focal point for Sexual Gender-Based Violence, if one exists.
- Provide medication only in exceptional cases, when acute distress is so severe that it limits basic functioning, such as being able to talk to people, for at least24 hours. In this case, and only when the survivor/victim's physical state is stable, give a 5mg or 10mg tablet of diazepam, to be taken at bed time, no more than 3 days. Refer the person to a professional trained in mental health for reassessment of symptoms the next day. If no such professional is available, and if the severe symptoms continue, the dose of diazepam may be repeated for a few days with daily assessments.
- **Be very cautious: benzodiazepine use may quickly lead to dependence, especially among trauma survivor/Victim s.**
- If the assault occurred more than 2 to 3 months ago and psychological counselling and support are not reducing highly distressing or disabling trauma-induced symptoms, such as depression, nightmares or constant fear and you cannot refer her; consider a trial of anti-depressant medication.

Treatment in children

With regard to STIs, HIV, hepatitis B, and tetanus, children have the same prevention and treatment needs as adults but may require different doses. Special protocols for children should be followed for all vaccinations and drug regimens. Routine prevention of STIs is not usually recommended for children. However, in low-resource settings with a high prevalence of sexually transmitted infections, presumptive treatment for STIs should be part of the protocol (see Annex 8 for sample regimens). Recommended dosages for post-exposure prophylaxis to prevent HIV transmission in children are given in Annex 10.

S/GBV and VAC MANAGEMENT PROTOCOL



Session 4.8: Counselling after clinical care

SESSION OBJECTIVES:

By the end of the session participants should be able to:

1. Discuss the psychological and emotional problems survivor/Victim s of sexual abuse/VAC face
2. Discuss the special consideration which should be taken when caring for boys and men who have suffered sexual abuse/VAC
3. Discuss how to deal with fears regarding pregnancy, HIV/STIs
4. Demonstrate ability to counsel S/GBV and VAC survivors/victims after clinical care

Introduction

Survivor/Victim is seen at a health facility immediately after the sexual abuse are likely to be extremely distressed and may not remember advice given at this time. It is therefore important to repeat information during follow-up visits. It is also useful to prepare standard advice and information in writing, and give the survivor/victim a copy before she leaves the health facility (even if the survivor/Victim is illiterate, she can ask someone she trusts to read it to him/her later).

Please Note: Give the survivor/victim the opportunity to ask questions and to voice her/his concerns before detailed counselling. This gives him/her the opportunity to open up for consideration during counselling.

1. Psychological and emotional problems:

- Medical care for survivor/Victim s of sexual abuse includes referral for psychological and social problems, such as common mental disorders, stigma and isolation, substance abuse, risk-taking behaviour and family rejection. Even though trauma-related symptoms may not occur or may disappear overtime, all survivors/victims should be offered a referral to the community focal point for Sexual and Gender-Based Violence, if one exists. A coordinated integrated referral system should be put in place as soon as possible.
- The majority of rape survivors/victims never tell anyone about the incident. If the survivor/victim has told you what happened, it is a sign that she trusts you. Your compassionate response to her/his disclosure can have a positive impact on his/her/his recovery.
- Provide basic, non-intrusive practical care. Listen but do not force him/her to talk about the event and ensure that /her/his basic needs are met. Because it may cause greater psychological problems, do not push survivors/victims to share their personal experiences beyond what they would naturally share.
- Ask the survivor/Victim if she has a ***safe place*** to go to and if someone she trusts will accompany her/him when she leaves the health facility. If she has no safe place to immediately go to, efforts should be made to find one for him/her .

Enlist the assistance of the counselling services, community services provider and law enforcement authorities, including police, probation officers or security officers as appropriate (see session 1). If the survivor/Victim has dependants to take care of, and is unable to carry out day-to-day activities as a result of /her/his trauma, provisions must also be made for her/his dependants and their safety.

- Survivor/Victim s are at increased risk of a range of symptoms, including:
  - Feelings of guilt and shame;
  - Uncontrollable emotions, such as fear, anger, anxiety;
  - Nightmares;
  - Suicidal thoughts or attempts;
  - Numbness;
  - Substance abuse;
  - Sexual dysfunction;
  - Medically unexplained somatic complaints;
  - Social withdrawal.
- Tell the survivor/victim that s/he has experienced a serious physical and emotional event. Advise her/him about the psychological, emotional, social and physical problems that she may experience. Explain that it is common to experience strong negative emotions or numbness after sexual abuse.
- Advise the survivor/Victim that she needs emotional support. Encourage her/him–but **do not force** her/him-to confide in someone she trusts and to ask for this emotional support, perhaps from a trusted family member or friend. Encourage active participation in family and community activities.
- Involuntary orgasm can occur during sexual abuse, which often leaves the survivor/victim feeling guilty. Reassure the survivor/victim that if this has occurred, it was a physiological reaction and was beyond his/her/his control.
- In most cultures, there is a tendency to blame the survivor/victim in cases of sexual abuse/VAC. If the survivor/victim expresses guilt or shame, explain gently that sexual abuse/vac is always the fault of the perpetrator and never the fault of the survivor/Victim. Assure her/him that she did **not** deserve to be sexually abused, that the incident was not his/her/his fault and that it was **not** caused by his/her/his behaviour or manner of dressing. Do not make moral judgements of the survivor/victim.

2. Special considerations for men/boys:

- Male survivors/victims of sexual abuse are even less likely than women to report the incident because of the extreme embarrassment that the typically experience.
  While the physical effects differ, the psychological trauma and emotional after-effects for men are similar to those experienced by women.
- When a man is anally abused, pressure on the prostate can cause an erection

and even orgasm. Reassure the survivor/victim that, if this has occurred during the sexual abuse, it was a physiological reaction and was beyond his control.

Paediatric and adolescents counselling is recommended.

3. Pregnancy:

- Emergency contraceptive pills cannot prevent pregnancy resulting from sexual acts that take place after the treatment. If the survivor/victim wishes to use a hormonal method of contraception to prevent future pregnancy, counsel her/him and prescribe this to start on the first day of her/his next period or refer her/him to the family planning clinic.
- Female survivors/victims of sexual abuse are likely to be very concerned about the possibility of becoming pregnant as a result of the sexual abuse. Emotional support and clear information are needed to ensure that they understand the choices available to them if they become pregnant:
  - There may be adoption or foster care services in your area. Find out what services are available and give this information to the survivor/victim.
  - Advise survivors/victims to seek support from someone they trust-perhaps a religious leader, family member, friend or community worker.
- Women who are pregnant at the time of a sexual assault are especially vulnerable physically and psychologically. In particular, they are susceptible to miscarriage, hypertension of pregnancy and premature delivery. Counsel pregnant women on these issues and advise them to attend antenatal care services regularly throughout the pregnancy. Their infants may be at higher risk for abandonment so follow-up care is also important.

If there is pregnancy as a result of sexual abuse

- A pregnancy may be the result of sexual abuse. All the options available, e.g. keeping the child and adoption should be discussed with the survivor , regardless of the individual beliefs of the counsellors, medical staff or other persons involved, in order to enable the survivor to make an informed decision.
- Children born as a result of sexual abuse may be mistreated or even abandoned by their mothers and families. They should be monitored closely and support should be offered to the mothers . It is important to ensure that the family and the community do not stigmatize either the child or the mother.

Foster placement and later, adoption should be considered if the child is rejected, neglected or otherwise mistreated. The risk of transmission of HIV or STI to partners following a sexual assault.

- The survivor/victim should be counselled on HIV/AIDS.
- The survivor/victim should be advised to use a condom with all partners for a period of 6 months (or until STI/HIV status has been determined).
- Give advice on the signs and symptoms of possible STIs and on when to return for further consultation.

Otherwise

- Give advice on proper care for any injuries following the incident, infection prevention (including perineal hygiene, perineal baths), signs of infection, antibiotic treatment, when to return for further consultation, etc.
- Give advice on how to take the prescribed treatments and on possible side-effects of treatments.

4. HIV/STIs:

Both men and women may be concerned about the possibility of becoming infected with HIV as a result of sexual abuse. While the risk of acquiring HIV through a single sexual exposure is small, these concerns are well founded in settings where HIV and/or STIs prevalence are high. Compassionate and careful counselling around this issue is essential.

Follow-up care at the health facility

- Tell the survivor/victim that she can return to the health service at any time if she has questions or other health problems. Encourage her/hiim to return in two weeks for follow-up evaluation of STI and pregnancy or refer appropriately.
- Give clear advice on any follow-up needed for wound care or vaccinations.

Session 4.9: Follow-up care of the survivor/Victim

SESSION OBJECTIVES

By the end of this session participants must be able to:

1. Describe the schedule for follow up care of adult and child survivors/victims

Introduction

It is possible that the survivor/Victim may not return for follow-up. therefore it is important to provide maximum in put during the first visit, as this may be the only visit.

All survivors/victims of sexual violence require follow-up whether they receive post-exposure prophylaxis or not.

Follow-up visits for survivor/Victim s who do not receive post-exposure prophylaxis

Two-week follow-up visit

- Evaluate for pregnancy and provide counselling.
- Check that survivor/victim has taken the full course of any medication given for STIs.
- If prophylactic antibiotics were not given, evaluate for STI, treat as appropriate, and provide advice on voluntary counselling and testing for HIV.
- Evaluate mental and emotional status; refer or treat as needed.

Three-month follow-up visit

- Evaluate for STIs and treat as appropriate.
- Assess pregnancy status if indicated.
- Test for syphilis if prophylaxis was not given.
- Provide advice on voluntary counselling and testing for HIV.
- Evaluate mental and emotional status; refer or treat as needed.

Follow-up visits of survivor/Victim s who receive post-exposure prophylaxis

One-week follow-up visit

- Evaluate post-exposure prophylaxis (side-effects and adherence).
- If not supplied at the first visit, provide the additional three-week supply of post-exposure prophylactic medication.
- Check that survivor/victim has taken the full course of any medication given for STIs.
- Evaluate for STI, treat as appropriate and provide advice on voluntary counselling and testing for HIV.

- Evaluate mental and emotional status; refer or treat as needed.

Four-weeks follow-up visit

- Evaluate for pregnancy and provide counselling.
- If prophylactic antibiotics were not given, evaluate for STIs, treat as appropriate and provide advice on voluntary counselling and testing for HIV.
- Evaluate mental and emotional status; refer or treat as needed.

Three-month follow-up visit

- Evaluate for STIs and treat as appropriate.
- Assess pregnancy status if indicated.
- Test for syphilis if prophylaxis was not given.
- Provide advice on follow-up voluntary counselling and testing for HIV for those who had a negative test during the first week.
- Offer voluntary counselling and testing for HIV to survivors/victims that were not tested before.
- Evaluate mental and emotional status; refer or treat as needed.

Care for child survivor/Victim

Good to know before you develop your protocol

- If it is obligatory to report cases of child abuse in your setting, obtain a sample of the national child abuse management protocol and information on customary police and court procedures. Evaluate each case individually.
- In some settings, reporting suspected sexual abuse of a child can be harmful to the child if protection measures are not possible.
- Find out about specific laws in your setting that determine who can give consent for minors and who can go to court as an expert witness.
- Health care providers should be knowledgeable about child development and growth as well as normal child anatomy. It is recommended that health care staff receive special training in examining children who may have been abused.

Follow-up

Follow-up care is the same as for adults. If a vaginal infection persists, consider the possibility of the presence of a foreign body, or continuing sexual abuse

MODULE 5
NETWORKING AND SOCIAL MOBILISATION FOR SEXUAL AND GENDER BASED VIOLENCE AND VIOLENCE AGAINST CHILDREN

DESCRIPTION OF THE MODULE:

The module is purposed to help participants to recognize that survivors/victims of S/GBV and VAC may have many needs that go beyond health care, including the need for legal advice, police protection, housing, economic support and other social services and no organization can single-handedly address the range of services that survivors/victims may need. This brings in the important aspect of networking; what is involved in identifying and engaging the relevant stakeholders to establish/strengthen networks for a holistic and synergistic approach to handling S/GBV and VAC within the community.

Challenges and the possible solutions in establishing linkages between the health system and other stakeholders will be discussed as well as the Referral pathway for S/GBV and VAC. Participants will develop a plan outlining the stakeholders within their local community, what they do and how they expect to work with them in establishing/strengthening linkages for response services needed to reduce the consequences of GBV and prevent further injury, trauma, harm and also to make the work easier for the health care workers.

This module seeks to empower health workers on how to participate in community mobilization and awareness raising for S/GBV and VAC prevention and response. This module emphasizes that S/GBV and VAC prevention depends on changing community norms about gender concerns (e.g. equality, equity, power relations, biases, stereotypes) and the acceptability of violence against women; interventions targeted at individuals are not enough.

Community mobilization programmes can change violence-related attitudes and behaviours and promote more equitable relationships between men and women. GBV prevention requires that society hold perpetrators accountable rather than blame the victim therefore ensuring a comprehensive service response often requires mobilizing coalitions and referral networks of service providers in the community to work together.

Health workers need to know that changing norms is essential for helping survivors/victims get help from families and community services. Community mobilization programs on S/GBV and VAC have the potential to improve women's

health and social-economic empowerment, another long-term strategy for preventing gender-based violence.

This module will include the following sessions:

1. Introduction to networking
2. The role of health workers in community mobilisation for S/GBV and VAC
3. Referral pathway

MODULE OBJECTIVES:

1. Identify specific S/GBV and VAC stakeholders in your setting
2. Reinforce understanding that effective S/GBV and VAC prevention and response involves many diverse services and service providers
3. Explore ideas about how to engage reluctant stakeholders

Session 5.1: Introduction to Networking

SESSION OBJECTIVES:

By the end of the session, participants will be able to:

1. Define networking
2. Explain the importance of networking and its benefits in S/GBV and VAC management
3. Discuss the process of establishing linkages among the stakeholders for S/GBV and VAC
4. Discuss the referral pathway for S/GBV and VAC management
5. Demonstrate ability to identify the stakeholders in your local community, what they do and how you expect to work with them in establishing/strengthening linkages for addressing S/GBV and VAC
6. Discuss the challenges and the possible solutions in establishing linkages between the health system and other stakeholders.

WHY NETWORK AND CHARACTERISTICS OF NETWORKS

Definition of Networking: Networking refers to the process where two or more organizations and/or individuals collaborate to achieve common goals.

Importance and benefits of Networking

There are at least two factors that make it essential for health organizations to look beyond their clinics when working on the issue of Sexual and Gender-Based Violence:

1. First, survivor/Victim s of violence may have many needs that go beyond health care, including the need for legal advice, police protection, housing, economic support and other social services. These needs may be as or more important than their need for health care and no organization can single-handedly address the range of services that survivors/victims may need.
2. The second reason why clinics need to look beyond their walls is to contribute to the broader policy debate and the effort to change attitudes toward women's rights and gender-based violence at the community, regional and national levels. Through legal advocacy and community education efforts, health organizations have an important role to play in challenging the social norms that perpetuate violence against women. Building alliances with other organizations takes time and effort and health programs often find it challenging to work with other sectors, particularly when staff members are over-stretched and resources are limited. Nonetheless, these efforts can lead to important gains, both for the institutions involved and more importantly for women living in situations of violence.

PROCESS OF ESTABLISHING NETWORKS AND LINKAGES:

a) ***Identify potential partners:*** Even in poor resource settings, there are likely to be a few organizations or individuals who are also working to address Sexual Gender Based Violence. The first step to working in a coordinated manner is to identify potential partners and to establish an initial contact to express your interest in collaborative efforts.

Example: Five step approach to organize formal networks (according to PAHO)

1. Familiarize yourself with the institutions in the local area that offer services that could be helpful for women and children who experience Sexual and Gender-Based Violence.
2. Identify a core group to develop a democratic process for ensuring the participation of key organizations.
3. Develop a process for raising awareness about the problem of sexual gender based violence.
4. Develop a strategic plan to address the problem based on a model of integral care agreed upon by the participating organizations.
5. Establish mechanisms of operation, for example, conferences, meetings, agreements, tasks and responsibilities.

b) ***Use a human rights framework***. Because each organization may prioritize different aspects of the issue of violence, (research, legal protection, health care, emotional support, etc.); it may be important to establish a common ground. A human rights frame work can provide groups with a clear set of principles and help establish a common agenda for the group. For instance, what is more important: health response to a survivor/Victim /victim or arresting and prosecuting a perpetrator?

c) **Ensure that networks hold members accountable.** Networks can serve as an important mechanism to ensure that survivors/victims have access to the different services they may need. In order for referral networks to be effective, however, organizations should not think that by making a referral they are washing their hands off the problem but should instead create mechanisms that allow for following up cases and for monitoring how individual organizations in the network collaborate.

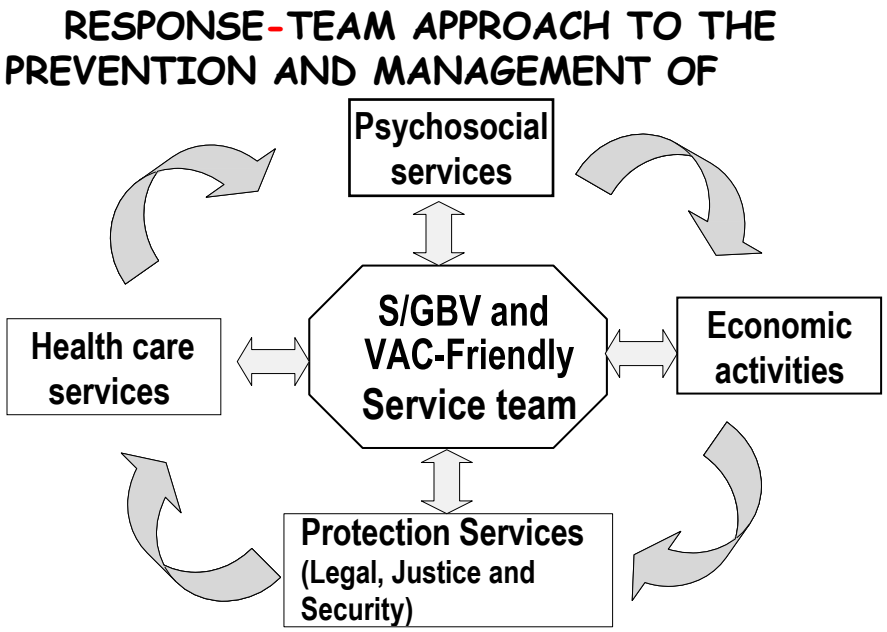
d) **Reflect on societal factors that contribute to violence in your community.** In addition to providing the specific services that survivors/victims may need, networks should also seek to have an impact on those factors that contribute to the occurrence of violence. This could include collaborating with organizations working to change cultural norms, as well as working to have an impact on issues, such as poverty or unemployment, that may ultimately lead many survivors/victims to remain in violent relationships. To this end, it is important to look to other organizations whose work may not focus specifically on violence, but that may offer great potential for collaboration (for instance, organizations working in the area of HIV/AIDS, equal opportunities, micro-credit, etc.)

e) **Use networks as opportunities for reflection and dissemination of lessons learned.** The lack of opportunities for collaboration among organizations within districts often

leads to a waste of time and precious resources. A network can also function as an important space for exchanging information and for jointly reflecting upon lessons learned. This may be particularly important if both government and civil society organizations are involved in the network since it may allow for lessons learned through pilot initiatives led by NGOs to be transferred to the public sector, where a greater number of survivors/victims of violence could be reached.

Networks in the management of S/GBV and VAC

The multi-sectoral approach is the framework upon which actions to prevent and respond to Sexual and Gender-Based Violence are built. The schematic diagram below represents how different actors work together to respond to the needs of victims/survivor/Victim s.



Prevention of and response to Sexual and Gender-Based Violence involves actions taken by many actors, most of whom represent one of four key sectors: health, psychosocial, safety and security, and legal/justice.

Health actors include: health facility staff, doctors, nurses, midwives, clinical officers, laboratory personnel, traditional birth attendants, community health workers, traditional health practitioners, health managers, administrators and co-ordinators, Ministry of Health officials and staff.

Psycho-social actors include: staff and volunteers in the community, members of the community, NGOs implementing S/GBV and VAC programme activities, educational staff, community groups, vocational training staff, income generation and micro-credit personnel and social services among others.

Protection

a. **Safety/security** actors include: police, security forces, security, Local Defence personnel, Local Council leaders, clan leaders, community members, religious leaders.
b. **Legal/justice** actors include: law enforcement bodies such as the police, judges and other officers of the court, legislators and law makers, community leaders, NGOs and advocacy groups working to improve national laws and policies concerning Sexual and Gender-Based Violence and Violence Against children.

BUILDING NETWORKS WITH OTHER ORGANIZATIONS:

The struggle to prevent violence, raising public awareness and advocacy for better legislation cannot be won by the health sectoral one as a single institution. For all of these reasons, health programs have a responsibility to reach out to other organizations working in the area of violence. This may include individual organizations, networks of organizations and institutions. For example:

1. *Social Action/Advocacy Networks:* These are groups of organizations that come together to carry out targeted actions such as changing policies, monitoring governments' compliance to international agreements or carrying out mass media campaigns.

   For instance, they may come together to organize events around commemorative days (16 days of activism against S/GBV and VAC) such as November 25, the International Day of Violence Against Women or they may join efforts to draft nationwide guidelines and protocols for addressing violence within the health system. In some settings, such networks do not exist or are not as active or effective as they could be. In that case, health programs may want to help build or revitalize local networks. In other cases, these networks do exist and health programs simply need to do more research to find out how they can participate.
2. *Referral Networks:* Groups of organizations that set up formal or informal agreements and procedures to facilitate survivor/victim's access to different services through referrals and counter-referrals.

Tips on making effective referral

a. Make sure that quality services (survivor/victim centred services) are offered at the places you are referring clients.
b. Provide details on the services you are recommending to help the survivor/Victim decide which services meet their needs. Details could include: location, type of organization, costs, hours, services offered and clinic availability of staff. It is important to keep this information easily accessible to everybody at the clinic. (Have referral directory or list given to all staff and hanged on the notice boards)
c. If your clinic does not have a written list of referral services, ask other clinics in the area to use theirs as a starting point for creating your own.
d. If there are a few formal services in your area/community talk to the survivor/Victim

about the informal community and family resources where she could find support.

e. If you give any written referral information to the survivor/victim, counsel her to hide it or help her to find ways of remembering the information without writing it down. If it is found by the perpetrator it could increase the survivor/victim's risk to violence.

f. Make sure the survivor/victim gives informed consent for any referrals you make and any information you disclose to other services.

Session 5.2: The role of health workers in community and social mobilization for S/GBV and VAC

SESSION OBJECTIVES:

By the end of the session, participants will able to:

1. Define the terms: community, community sensitization and mobilization
2. Explain the benefits of mobilization for S/GBV and VAC prevention and response
3. Explain the role of health workers in community mobilization for prevention and response to S/GBV and VAC
4. Explain why health workers are key actors to assist the community in the prevention and management of S/GBV and VAC.
5. Discuss key messages to target groups for S/GBV and VAC prevention and response
6. Discuss the role of the various community groups/institutions in prevention and response to S/GBV and VAC
7. Discuss appropriate opportunities, methods, channels for S/GBV and VAC prevention and response
8. Discuss the challenges to community mobilization and suggest possible solutions

DEFINITION OF A COMMUNITY

A community is a group of people living together in same environment, sharing common interests, communal problems, concerns and facilities.

A Community Leader is a member of the community who is knowledgeable, respectable, and influential and guides others towards community development. Community leaders may include the elderly, the educated, and ordinary people who possess useful knowledge of the past, tradition, traditional medicine or some other aspect of community life. They also include political, religious, youth leaders and cultural leaders, etc.

Categories of Community Leadership

- Historically, community leadership constituted three categories; traditional, religious and political leadership. Traditional leaders e.g. cultural leaders, herbalists; religious leaders e.g. Reverends, Pastors, Priests, Imams; political leaders e.g. MPs, RDCs, LCs, celebrities, etc.
- However, presently, community leadership includes all individuals who have a role to play in community development e.g. police, teachers, health workers, development officers and other community leaders.

Community Sensitisation is the process of making the community aware of facts, events or situations. Sensitisation may also involve training of leaders and followers to be observant and prepared for particular situations.

Social Mobilisation involves actions and processes to reach, involve, and influence all relevant segments of society across all sectors, from the national to the community level to provide the enabling environment for positive behaviour and social change

DEFINITION OF COMMUNITY MOBILIZATION

It is a process whereby people are brought together to perform a desired task in the fulfilment of its objectives, in this case, the prevention and response to S/GBV and VAC.

Benefits of Community Mobilisation for S/GBV and VAC prevention and Response:

(i) The use of existing channels makes it possible to have a nationwide-scale impact.

(ii) Encourages the community to take lead in the prevention and response to S/GBV and VAC.

(iii) Promotes participation of various duty bearers in the fulfilment of the rights of the vulnerable groups,

(iv) Enhances partnership between community and development partners hence, gives a supportive environment, empowers the weak and vulnerable to capture their voices.

(v) Enhances interface between communities and service providers.

(vi) It bridges the gap between the knowledge and practice leading to behaviour change at the individual level and social change at the community level.

(vii) Promotes willingness to accommodate each other's divergent views and addresses power relations in communities including the role of women and children.

(viii) It encourages participatory planning and brings on board all resourceful people (e.g. retired officers) and other development actors.

(ix) It enhances information sharing and promotes common understanding that leads to increased resource mobilization, community accountability of resources and effective monitoring of progress.

(x) Promotes community ownership and ensures sustainability of prevention and response to S/GBV and VAC efforts.

One of the community mobilization approaches is SASA. SASA Approach is a ground breaking community mobilization approach developed by *Raising Voices for Preventing Violence Against Women and Children.* SASA inspires and enables communities to re think and reshape social norms positively.

SASA Approach:

- Recognises that change is possible and that everyone can do something whether big or small to create change in their communities.
- Uses a benefits-based approach that doesn't scare individuals from participating.
- Recognises that social change is a gradual process that calls for the involvement of all stakeholders
- Focuses on the cliché that prevention is better than cure and seeks to prevent violence before it happens through change of norms, behaviours and attitudes that perpetrate violence.
- Uses simple messages/materials that can be understood by everyone including those who cannot read and write.
- Is a community led initiative which is spearheaded by everyday men and women. There are experts from outside.
- Uses local resources and is inexpensive–for example activities can be done anywhere e.g. on verandas at water sources, drinking joints, etc. rather than in a workshop like audience.
- Works with everyone

Why health workers are key actors in mobilizing the community to prevent and respond to S/GBV and VAC

- Health workers are part of the community in which they live.
- Health workers are often the first contact of survivors/victims and have knowledge of the magnitude and consequences of the problem
- Health workers are trained in the management of S/GBV and VAC and the laws/legal requirements related to S/GBV and VAC.

  NOTE: It is now a requirement that all health workers are trained to manage S/GBV and VAC survivors/victims
- They can integrate S/GBV and VAC prevention and response into their routine activities.
- They know the referral system
- Participate in the follow-up.
- Provide psychosocial and relevant guidance to the survivors/victims of S/GBV and VAC
- Able to identify and manage the injuries on the survivors/victims of S/GBV and VAC
- Legally mandated to manage S/GBV and VAC survivors/victims and provide appropriate support
- Are seen as sources of information and are respected in the communities

Target Groups:

i) Organizations/Institutions working in the community, mobilized and sensitized on

S/GBV and VAC:

a) Enablers and supporters, e.g. Ministries, International Organisations (UNWomen, UNICEF, UNFPA, WHO, OXFAM, IRC, Development partners, etc.)

b) Organizations/Institutions which organize others e.g. Executives Chiefs, Faith Based Organization and traditional institutions

ii) Women and men groups: These groups are important forces in community-based prevention and response to S/GBV and VAC as they are best able to influence changes in knowledge, attitudes, and behaviour among their male/female counterparts in the community.

iii) Service providers e.g. Health Workers, Teachers, Extension Field Workers, Market sellers, Shop Owners, Taxi Drivers, Housewives and House girls, Commercial Sex Workers, Boda-Boda, etc.

iv) Consumers/beneficiaries, e.g. Community Development Officers, mothers, men, adolescents, youths, children, disabled and vulnerable groups, etc.

Key Messages to the Target Groups for S/GBV and VAC prevention and response

- S/GBV and VAC is rampant in our communities but often tolerated and therefore unreported.
- Sexual Gender Based Violence is caused by power imbalance between men and women.
- GBV has serious health consequences for women e.g. physical injuries, STIs and gynaecological problems
- GBV is unacceptable and can never be justified
- Sexual and gender-based violence is a major cause of disability and death among women, children and also men.
- Women are more vulnerable than men to S/GBV and VAC because some cultural norms or traditional norms are used to justify gender based violence.
- Sex workers are equally at risk of S/GBV and VAC and they are entitled to access health care services
- Perpetrators use sexual violence as a means to control victims and as a way of expressing defeat and humiliation (in armed conflicts).
- Sometimes money or gifts are offered before/after sexual abuse
- Some men tend to use their position to sexually abuse females who are their subordinates.
- S/GBV and VAC may not always be physical. It may also be verbal, economical and emotional.
- Close relationships that are undefined between the opposite sexes may be a risk factor.
- Walking alone at night and or in dark places is risky
- Alcohol and Drug Abuse increases the risk for S/GBV and VAC

- Social gatherings especially at night are a risk
- It is the duty of everyone to report S/GBV and VAC cases e.g. to Police, HCPs, etc.
- S/GBV and VAC thrives on silence. Therefore seek help if you experience S/GBV and VAC.
- Women and girls who have physical and mental disability are often more at risk of S/GBV and VAC and thus the need to understand the risk that disability brings to the lives of women and girls.
- Displacements resulting from emergences or crisis such as social, natural and political calamities increases women's risk for S/GBV and VAC, because of the breakdown of social systems and the fact that often attention is focused on providing food and basic shelter to the group rather than the security and safety of women. Often men abuse women with impunity.
- Post Exposure prophylaxis is available and reduces the chances of contracting STIs including HIV. However it is important for the survivors/victims to come in time (72hours).
- Emergency contraception if given in time (120hours) can prevent unintended pregnancy resulting from rape. However, it does not cause abortion to an already existing pregnancy.

What communities should know:

Members of the community should know the following:

The services available for S/GBV and VAC survivors/victims and where they can be found; (laboratory services available for forensic testing, DNA analysis can be done, screening for pregnancy, STIs including HIV and Hepatitis B testing)

- The role of the community in preventing and responding to S/GBV and VAC
- About PEP and Emergency Contraception; who is eligible, where and when the service is offered
- The resources and capacities available and who to contact 24 hours a day, 7 days a week;
- Benefits of seeking medical care;
- That S/GBV and VAC survivor/Victim s should seek care immediately or as soon as possible after the incident, without bathing or changing clothes;
- That S/GBV and VAC survivors/victims can trust the service provider to treat them with dignity, maintain their safety and respect their privacy and confidentiality;
- Hours when the services are available; this should specify whether it is 24hours a day, 7 days a week.
- The legal requirements with regard to forensic evidence
- The legal requirements with regard to reporting of S/GBV and VAC cases to relevant authorities
- The national policies and guidelines regarding management of the possible medical consequences of sexual abuse e.g. emergency contraception, testing

and prevention of HIV infection and abortion (see protocols)

Opportunities, methods, channels and benefits of Community Mobilization for S/GBV and VAC prevention and response

Opportunities:

- Presence of trained health providers in S/GBV and VAC prevention and management
- Health Management Committee members
- Antenatal and outpatient services
- Presence of good leadership
- Stability and peace in the area
- Availability of *services* and local resources
- Political Commitment
- Literacy
- Availability of Socio- economic infrastructure
- Presence of ready organised groups
- Use of common language

Methods

- Group Discussions
- Health Talks, Lectures and seminars
- Music Dance and Drama
- Exhibitions
- Community Dialogue
- Role Play
- Storytelling
- Interviews
- Field Trips
- Testimonies etc.

Channels

- Media both Print and Electronic
- Seminars/Workshops/Conferences
- IEC Materials e.g. Posters and Leaflets
- Integrated Community Outreaches
- Home visiting
- Community leaders
- Community based organizations e.g. Faith-Based Organizations and Social Clubs

- Health Workers and Other Sector Extension Workers

Roles and Responsibilities of Health Workers in Community Mobilization and Sensitization of Target Groups for S/GBV and VAC

- Identifying cases of S/GBV and VAC who come to the health centres
- Sensitise clients who seek services about health consequences of gender-based violence and the available services.
- Facilitate girls and women to access other services in the community through referral. Handle cases without blame and in a non-judgemental manner (non-discrimination).
- Conduct community-based education on S/GBV and VAC prevention and availability of services.
- Offer health care and follow-up support for the survivors/victims who report to the health units.
- Refer S/GBV and VAC survivors/victims to the appropriate authorities
- Support/do not shun activists speaking out against violence
- Provide platform/space for community mobilization activities
- Support individuals and organizations conducting community mobilization activities.
- Learn about activities in your community and endeavour to participate
- Identify individuals and groups that conduct community mobilization activities in your community
- Add your voice to those who speak out against violence.
- Provide space for activities e.g. at waiting areas in your health facility and display IEC materials.
- Provide information and referrals for clients e.g. places and specific areas where they can participate in community mobilization activities.
- Integrate S/GBV and VAC messages into your outreach activities e.g. HIV/AIDS awareness raising activities.
- Participate in trainings/learn more about S/GBV and VAC
- Provide appropriate services for survivors/victims. This will build the power within them to change their situation.
- Participate in public events in your community and talk about S/GBV and VAC services.
- Health workers should work hand-in-hand with various community groups and institutions in the prevention and management of S/GBV and VAC survivors/victims. Such groups and institutions may include Schools, Religious Institutions, Community leaders, etc.)

Roles and Responsibilities of Senior Women and Men Teachers in Prevention of S/GBV and VAC in Schools and Higher Institutions of Learning:

As much as there are various stakeholders who handle S/GBV and VAC services senior women and men teachers are key because they interact with a highly vulnerable group. Generally teachers are also agents of change during the course of their work and when interacting with pupils/students in/outside classroom teaching. They have opportunities to influence positive lifestyles of the peoples/students during the school career by:

- Being exemplary
- Informing girls/boys about the various forms of S/GBV and VAC and encouraging them to report all cases to relevant authorities
- Explaining the concept of and dangers associated in S/GBV and VAC
- Introducing Adolescent Friendly Health services into school
- Educating girls and boys to recognise threats of sexual violence
- Educating girls and boys on life skills
- Watching out for signs of violence
- Educating on children's and adult's rights
- Providing information on:
  - Where to report if S/GBV and VAC occurs sexual abuse can happen anywhere e.g. in gardens, paths to the wells, churches, homes, etc.

    Sexual abuse can be perpetrated by people they know and trust very well e.g. parents, cousins, and neighbours.
- Teach them to avoid risky places such as discos and risky behaviours such as taking alcohol
- The Teacher has an added role of counselling pupils/students considering the following key issues:
  - Effective counselling can restore hope where there is despair and anxiety.
  - The school should put in place counselling services for pupils and
  - Students and staff to handle all issues including S/GBV and VAC
  - Dissemination of Information and Strengthening linkages with other service providers such as health workers, religious and social workers
  - Ensure that school health is functional and pupil/students have facilities to get their minor illnesses attended to
  - Encourage and form school health clubs

NOTE: The roles of teachers are particularly emphasized because pupils spend more time in school than at home.

The Role of Community groups/institutions in the Prevention and response to S/GBV and VAC

- Planning and demanding services e.g. data collection
- Conducting awareness-raising and behaviour change activities to influence changes in socio-cultural norms and promote respect for human rights and women's rights.
- Implementation of health and other sector programs and policies
- Monitoring, supervision and evaluation
- Sharing information with the S/GBV and VAC working group and actively participate in efforts to strengthen prevention strategies.
- Providing emotional support through culturally appropriate and sustainable mechanisms.
- Maintaining awareness of S/GBV and VAC risks and issues in the setting, communicate those to security actors and the S/GBV and VAC working group, and engaging in problem-solving discussions to continuously strengthen prevention strategies
- Actively promoting respect for human rights and women's rights, including equal participation of women and children
- Reporting the S/GBV and VAC perpetrators to relevant authorities
- Follow up S/GBV and VAC survivor/Victim s
- Committing to be non-violent, live as examples
- Holding perpetrators accountable for their violent actions
- Providing funds for community mobilization programmes.

CHALLENGES TO COMMUNITY MOBILISATION AND POSSIBLE SOLUTIONS

(i) **Challenges**

- New interventions are looked at with suspicion
- Limited of knowledge on S/GBV and VAC issues.
- Ignorance on S/GBV and VAC Programs by community leaders may undermine the intervention.
- The Community may reject the assigned health workers which makes the community dialogue difficult
- Inappropriate approaches and languages

(ii) **Possible Solutions**

For any Community Based activity to succeed, the following should be done:

- While carrying out community sensitization, expectations and roles must be explained clearly
- Preparation for sensitization must be done well in advance.
- The community must feel the need to participate in it to create a sense of ownership

- The community must collaborate with organizations from various sectors (police, judiciary, social support, etc.) and with programs focusing on other areas, such as those tackling teenage pregnancy, substance abuse, etc.
- People have a positive attitude to enable health workers to perform
- Health workers must be aware of biased information, especially when the community members know what you want to hear
- Health workers should be mindful of the communities, culture and values e.g. dress code
- A multi-sectoral approach should be used to tap the expertise from different parties
- Be aware that meaningful change takes time but it is possible
- The community must know that prevention is cheaper than response
- HCP should not see himself as—expert willing to listen and learn from others.

Session 5.3: Help-Seeking and Referral Pathway

Use the following template to fill in details of the referral pathway for your setting. These referral pathways must be specific to one site (village, camp, town or other location).

<table>
<tr><th colspan="4">TELLING SOMEONE AND SEEKING HELP (REPORTING</th></tr>
<tr><td colspan="2">Survivor/Victim tells family, friend, community member; that person accompanies the survivor/Victim to the health or psychosocial—entry point:</td><td colspan="2">Survivor/Victim self-reports to any service provider</td></tr>
<tr><td colspan="4">↓</td></tr>
<tr><th colspan="4">IMMEDIATE RESPONSE</th></tr>
<tr><td colspan="4">The service provider must provide a safe, caring environment and respect the confidentiality and wishes of the survivor/Victim; learn the immediate needs; give honest and clear information about services available. If agreed and requested by the survivor/Victim, obtain informed consent and make referrals; accompany the survivor/Victim to assist her in accessing services whenever possible.</td></tr>
<tr><td colspan="2">Medical/health care entry point
[Enter name of the health centre(s) in this role]</td><td colspan="2">Psychosocial support entry point
[Enter name of the psychosocial provider(s) in this role]</td></tr>
<tr><td colspan="4">↓</td></tr>
<tr><th colspan="4">IF THE SURVIVOR/VICTIM /VICTIM WANTS TO PURSUE POLICE/LEGAL ACTION OR IF THERE ARE IMMEDIATE SAFETY AND SECURITY RISKS TO OTHERS</th></tr>
<tr><td colspan="4">Refer and accompany survivor/Victim to police/security to legal assistance/protection officers for information and assistance with referral to police</td></tr>
<tr><td colspan="2">Police/Security
[Enter specific information about the security actor(s)to contact-including where to go and/or how to contact them]</td><td colspan="2">Legal Assistance Counsellors or Protection Officers
[Enter names of organisations]</td></tr>
<tr><td colspan="4">↓</td></tr>
<tr><th colspan="4">AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES</th></tr>
<tr><td colspan="4">Over time and based on survivor/Victim /victim's choices can include any of the following (details in Section6):</td></tr>
<tr><td>Health care</td><td>Psychosocial services</td><td>Protection, security and justice actors</td><td>Basic needs, such as shelter, ration card, children, services, safe shelter or other</td></tr>
</table>

Key points to remember:

(i) ***Joining networks of organizations can benefit health programs and allow them to contribute to a broader effort to combat Sexual and Gender Based Violence.*** In the long run, collaborating with other organizations not only benefits the health program, but also offers a chance for health care organizations to participate in the broader policy debate by raising awareness of gender based violence as a public health issue.

(ii) In some settings, health care organizations may need to establish or revitalize networks. In some settings, formal social action or referral networks do not exist, or are not as active or effective as they could be. In that case, health organizations may need to build new networks or work to revitalize existing ones. The first step in the process is to identify institutions that already work on issues related to violence against women and children. Depending on the level of resources available, a health program may want to start with informal collaboration with a small number of organizations or it may want to try to organize a more formal collaboration with a large network of organizations.

(iii) To encourage other organizations to collaborate, it may be necessary to raise their awareness on Sexual and Gender-Based Violence as a public health issue. To encourage other organizations to collaborate in referral or social action networks, it may be necessary for a health program to sensitize others about the magnitude of the problem and the need to address it in an integrated way. Making emphasis of the negative health consequences of Sexual and Gender Based Violence.

MODULE 6
MONITORING AND EVALUATION OF S/GBV and VAC SERVICES

DESCRIPTION OF THE MODULE:

The purpose of the module is to help participants appreciate the importance of accurate data management (collection, analysis, interpretation, reporting and dissemination) and the need for monitoring and evaluation of S/GBV and VAC services. The participants will be oriented to standardized records and reporting formats for S/GBV and VAC services. Using simulation exercises in the classroom participants will practice data collection using the various tools and monitoring of services provided for S/GBV and VAC survivors/victims.

This module will include the following sessions:

1. Data management
2. Monitoring and evaluation of S/GBV and VAC services

MODULE OBJECTIVES:

1. Maintain accurate S/GBV and VAC records at health facility level
2. Use service data to monitor and evaluate own services provided on S/GBV and VAC.
3. Use S/GBV and VAC data to support medical legal services/court proceedings

Session 6.1: Data Management

SESSION OBJECTIVES:

By the end of the session, trainees will be able to:

1) Explain the meaning of data.
2) Explain the purposes of collecting, managing and keeping S/GBV and VAC data.
3) Describe the type of data to be collected for S/GBV and VAC management.
4) Explain the tools used in collecting S/GBV and VAC data.
5) Discuss issues to consider in S/GBV and VAC data management
6) Discuss the limitations in managing S/GBV and VAC data.
7) Demonstrate ability to collect data for S/GBV and VAC using the approved tools.

WHAT IS DATA?

Data is unprocessed information. Unprocessed information is also called raw data. Raw data refers to a collection of numbers, characters, images or other outputs from devices that collect information to convert physical quantities into symbols that are unprocessed.

PURPOSES OF DATA MANAGEMENT IN S/GBV and VAC SERVICE DELIVERY.

Accurate data management is to:

- Ensure that client's medical records are complete and secure.
- Provide evidence for future legal proceedings.
- Protect client's safety and wellbeing,
- Monitor health facilities and other stakeholders work in the area of S/GBV and VAC .
- Facilitate the formulation of evidence based S/GBV and VAC Policies
- Determine the demand for S/GBV and VAC services.
- Be used for future reference e.g. in research
- Provide the information for effective planning and accountability at both local and national levels to improve service delivery.

NOTE: *S/GBV and VAC data is managed using health management information systems (HMIS). HMIS plays an important role in the prevention and response to S/GBV and VAC. Therefore S/GBV and VAC data should be accurately collected and securely stored*.

TYPES OF DATA TO BE COLLECTED:

1. Bio demographic data of the survivor/victim. Take note of the time of incidence and the medical intervention.
2. Clinical and laboratory findings
3. Forensic evidence collected.
4. Provider/client service interventions (HIV test, PEP, ECP, care of the injury etc.)
5. Referrals and reasons for referral.
6. Follow-up findings.

S/GBV and VAC DATA COLLECTION TOOLS:

The following are the tools used in S/GBV and VAC data management:

1. Consent form (Annex 2).
2. Medical History and Examination form for S/GBV and VAC (Annex 3). If not available any other medical form can be used.
3. Pictograms (Annex 5)
4. Medical Certificates (for Child and Adult) (Annex 7).
5. HIV Post-Exposure documentation form (Annex 10).
6. S/GBV column in all health facility registers.
7. Authorization form/consent to release information to the third party.
8. Integrated Family planning register (cover routine screening for FP includes ECP)
9. Police Form 3, 3A, 24&24A
10. HMIS reporting tools such as Form 105, 108 (monthly in-patient and out-patient forms), OPD register

ISSUES TO CONSIDER IN S/GBV and VAC DATA MANAGEMENT

- Confidentiality must be ensured at all times. Persons charged with collecting information from the survivor/Victim should be appropriately trained on how to fill out the forms and how to act in accordance with the guiding principles. They should carry out their responsibilities with compassion, in confidence and with respect for the survivor/victim. Training on the proper completion of incident report forms will include determining the appropriate case definition for each reported incident of GBV.
- The *History and examination form* contain extremely confidential and sensitive information and may only be shared with others under certain circumstances. Original completed Incident Report Forms and Consent Forms are maintained in locked files. In a camp setting, the files should be kept in the office outside the camp.
- Filling the *History and examination form* must be done consistently by all who use the form. Consistent guidance and training should be provided to ensure that all fields are filled in the same way by all who complete this documentation.

- Consistent data collection on reported GBV incidents also includes documenting the types of GBV incidents (on the incident report form) using consistent case definitions. Permission/approval to release information to the police, court, and support organisations relatives or to any other person, etc. should be provided by the survivor/Victim. If S/GBV data is to be used for reference and research it should not bear the name or identity of the survivor/Victim.

FACTORS THAT LIMIT EFFECTIVE S/GBV and VAC DATA MANAGEMENT:

CLIENT:

- The fear of stigmatization
- Bias towards law enforcement units such as the police.
- Fear to report due to the previous negative experiences e.g. of failure to get assistance, being followed up by the perpetrators, fear of court proceedings.
- Poor record management e.g. lack of stationery, poor storage.
- Lack of knowledge and skills to handle S/GBV and VAC data.
- Negative attitude of health workers towards S/GBV and VAC.
- Workload

Facility:

- Inadequate infrastructure and privacy in the health facilities to handle S/GBV and VAC clients.
- Lack of relevant S/GBV and VAC data collection tools.
- Lack of storage facilities

Session 6.2: Monitoring And Evaluation Of S/GBV and VAC Services

SESSION OBJECTIVES:

By the end of the session, trainees will be able to:

1. Define monitoring and evaluation
2. Explain the purposes of monitoring and evaluating S/GB and VAC services
3. Discuss the indicators to be used in monitoring the S/GBV and VAC management programme.
4. Discuss the support supervision tool used in monitoring S/GBV and VAC.
5. Demonstrate ability to utilise monitoring and evaluation skills.

WHAT IS MONITORING?

Monitoring is the on-going, systematic and purposeful collection of information to assess progress towards the achievement of objectives, outcomes and impacts. It can signal potential weaknesses in programme design, allowing adjustments to be made. It is vital for checking any changes (positive or negative) to the target group that may be resulting from programme activities. It is usually an internal management activity which involves;

- Day-to-day follow up of activities during implementation to measure progress and identify deviations
- Routine follow up to ensure activities are proceeding as planned and are on schedule
- Routine assessment of activities and results
- Answers the question, "what are we doing?"
- Assess progress of implementation of the work plan against schedules, how inputs are being used to achieve outputs and the processes involved, assess these against timeline and the planned and achieved targets. At each process of monitoring indicators are used.

Therefore, monitoring provides continuous feedback on whether S/GBV and VAC, a specific health problem or condition is on course or requires redefining and if results reveal that these activities are being implemented according to the plan, assess the extent to which the services are being utilized. This is a process of overseeing the implementation of activities in order to assess performance and identify the gaps for change in the management.

WHAT IS EVALUATION?

Evaluation is the systematic and objective assessment of an on-going or completed project, programme or policy, its design, implementation and results. The aim is to determine the relevance and fulfilment of objectives, efficiency, effectiveness, impact and sustainability. It focuses on whether or not a programme has met its stated objectives and is usually intended for internal use.

Evaluations can be periodic/formative, conducted to review progress, predict a project's likely impact and highlight any necessary adjustments in project design; or terminal/summative, carried out at the end of a project to assess project performance and overall impact. Evaluation involves value judgement and hence it is different from monitoring (which is observation and reporting of observations).

NOTE: *Evaluation seeks to find out the change that has occurred from the beginning of the implementation of the program to the current time.*

PURPOSE OF MONITORING AND EVALUATION

- Assess how well a policy or programme is achieving its intended target.
- Ensure quality and learning to improve activities and services
- Tracks inputs and outputs and compares them to plan
- Determining whether the inputs in the program/project are well utilized
- Identifies and addresses problems
- Ensure effective use of resources
- Strengthens accountability
- Program management tool
- Measures effectiveness and benefits
- Determines costs incurred vis-à-vis benefits attained

MEANING OF AN INDICATOR AND EXAMPLES:

Indicators are the observations/results that we use to measure progress and achievements of the set objectives for managing S/GBV and VAC Survivors/victims at the health facility. The following indicators can be used to monitor progress of the S/GBV and VAC management programme at the health facility level. These indicators are developed on basis of the general objectives for integrating S/GBV and VAC into the health management system.

Indicators

National/Districts

1. Proportion of health workers trained on the management and response to S/GBV management
2. Proportion of health facilities with PEP kits.
3. Proportion of health facilities with ECP
4. Proportion of health facilities with both PEP and ECP
5. Number of S/GBV and VAC cases managed at the health facilities
6. Proportion of health workers who have received a CPD/CME in the last 6 months (per district/per facility)
7. Inclusion of S/GBV and VAC data in monthly reports (HMIS).
8. S/GBV data disseminated to the MOH and other stakeholders routinely

Health Facilities

1. Proportion of health workers trained on the management and response to S/GBV and VAC
2. Proportion of health workers who have received a CPD/CME on S/GBV and VAC in the last 6 months.
3. Availability of PEP (HIV testing kits and ARVs) in the health facilities continuously for the last three months.
4. Availability of ECP at the health facilities in the last three months.
5. Availability of pregnancy test kits at the health facilities in the last three months.
6. Availability of the standard data collection tool on S/GBV and VAC (history and examination documentation form on S/GBV and VAC)
7. Number of GBV cases identified and documented at the health facility
8. Proportion of S/GBV and VAC clients who seek services within 72 hours of the incident.
9. Correct and timely filling of monthly reports (HMIS) with S/GBV and VAC data
10. Number of meetings held to disseminate S/GBV and VAC data to the district, MOH and other stakeholders routinely

Output indicators

1. Number of S/GBV and VAC cases clinically managed at health facility
2. Number of GBV successfully referred to other services. (referred and feedback received)
3. Number of health workers who have testified in court for GBV cases.
4. Number of S/GBV and VAC cases who came back for further follow-up
5. Number of S/GBVand VAC survivors/victims who have received PEP
6. Number of S/GBV and VAC survivors/victims who have received ECP
7. Number of S/GBVand VAC survivors/victims who have received PEP and EC

MODULE 7
PREVENTION

ANNEXES

Annex 1: Minimum care for rape survivor/Victim's in low-resource settings

1. **Protocol Available?**
   - Written medical protocol in language of provider
2. **Personnel**
   - Trained (local) health care professionals (on call 24 hours/day)
   - A "same language" "same sex" health worker or companion in the room during examination

3. Furniture/Setting

- Room (private, quiet, accessible, with access to a toilet or latrine)
- Examination table
- Light, preferably fixed (a torch may be threatening for children)
- Access to an autoclave to sterilise equipment

4. Medicines and Supplies

- "Sexual Assault/Rape Kit" for collection of forensic evidence, could include: Speculum (preferably plastic, disposable, only adult sizes), Tape measure for measuring the size of bruises, lacerations, etc.
- Set of replacement clothing
- Supplies for universal infection control precautions
- Resuscitation equipment
- Sterile medical instruments (kit) for repair of tears, and suture material
- Needles, syringes
- Cover (gown, cloth, and sheet) to cover the survivor/Victim during the examination.
- Sanitary supplies (pads or local cloths)
- Treatment of STIs as per country protocol
- Treatment for S/GBV and VAC-related mental health conditions
- Treatment for anaphylactic reactions
- ARVs for Post Exposure Prophylaxis
- Emergency contraceptive pills and/or copper-bearing intrauterine device (IUD)
- Vaccines for tetanus and Hepatitis B
- For pain relief (e.g. paracetamol)

- Local anaesthetic for suturing
- Antibiotics for wound care

5. Administrative Supplies

- History and examination form for S/GBV and VAC with pictograms
- Medical certificate
- Consent forms
- Information pamphlets for post-rape (for survivor/Victim)
- Safe, locked filing space to keep records confidential

Things to note:

Collecting minimum forensic evidence

Evidence should only be collected and released to the authorities with the survivor/Victim's consent (see Step 5 of the S/GBV and VAC management protocol).

A careful written recording should be kept of all findings during the medical examination that can support the survivor/Victim's story, including the state of her clothes. The medical chart is part of the legal record and can be submitted as evidence (with the survivor/Victim's consent) if the case goes to court.

Keep samples of foreign debris present on her clothes or body and damaged clothing (if you can give the survivor/Victim replacement clothing) which can support her story.

If a microscope is available, a trained health care provider or laboratory worker can examine wet-mount slides for the presence of sperm which proves penetration took place.

Minimum examination

A medical examination should be done only with the survivor/Victim 's consent as described in Step 5 of the S/GBV and VAC management protocol. It should be compassionate, confidential, and complete as indicated.

Minimum treatment

Give compassionate and confidential treatment as follows:

Treatment and referral for life-threatening complications;

Treatment or preventive treatment for STIs;

Emergency contraception;

Care of wounds;

Supportive counselling;

Referral to social support and psychosocial;

Counselling services.

Annex 2: Sample consent form

Notes on completing the consent form

Consent for an examination is a central issue in medico-legal practice. Consent is often called "informed consent" because it is expected that the patient (or his/her parent(s) or guardian) will receive information on all the relevant issues, to help the patient make a decision about what is best for her/him at the time.

It is important to make sure that the patient understands that her consent or lack of consent to any aspect of the examination will not affect her access to treatment and care.

The health care provider must provide information in a language that is understood by the patient or his/her parent/guardian to ensure that he/she understands the following:

- What the history-taking process will involve.
- The type of questions that will be asked and the reason those questions will be asked.
- What the physical examination will involve.
- What the pelvic examination will involve.
- That the physical examination, including pelvic examination will be conducted in privacy and in a dignified manner.
- That during part of the physical exam, the patient will lie on an examination couch.
- That the health care provider will need to touch her/him for the physical and pelvic examinations.
- That a genito-anal examination will require the survivor/Victim /victim to lie in a position where her/his genitals can be adequately seen with the correct lighting.
- That specimen collection (where needed) involves touching the body and body openings with swabs and collecting body materials such as head hair, pubic hair, genital secretions, blood, urine and saliva. That clothing may be collected, and that not all of the results of the forensic analysis may be made available to the patient and why.
- That she/he can refuse any aspect of the examination she/he does not wish to undergo.
- That she/he will be asked to sign a form which indicates that she/he has been provided with the information and which documents procedures that she/he has agreed to.

Inform the survivor/Victim /victim that if and only if, she/he decides to pursue legal action, the information told to the health worker during the examination will be conveyed to relevant authorities for use in the pursuit of criminal justice with her consent.

THE REPUBLIC OF UGANDA

Sample Consent Form

Name of Facility ……..

Note to the health worker:

After providing the relevant information to the survivor/Victim /victim as explained above (*notes on completing the consent form*), read the entire form to the patient (or his/her parent/guardian), explaining that she can choose to refuse any (or none) of the items listed. Obtain a signature, or thumb print with signature of a witness.

I, ……..(print name of survivor/Victim)

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

	Yes	**No**
Conduct a medical examination	☐	☐
Conduct pelvic examination	☐	☐
Collect evidence such as body fluid samples, clothing, hair combings, scrapings or cutting of fingernails, blood sample, and photographs	☐	☐
Provide evidence and medical information to the police and/or courts concerning my case. This information will be limited to the results of this examination and any relevant follow-up care provided.	☐	☐

I understand that I can refuse any aspect of the examination which I don't wish to undergo.

Signature/thumbprint of Survivor/Victim ……

Date: ……

Name of Witness……

Signature/thumbprint of Witness: ……

Annex 3: History and examination form for S/GBV and VAC

THE REPUBLIC OF UGANDA

HISTORY AND EXAMINATION FORM

FOR SEXUAL AND GENDER BASED VIOLENCE

To be completed in legible handwriting and signed on every page

A. DEMOGRAPHIC INFORMATION

1. Name of Health Facility
2. Time ☐☐:☐☐ Day ☐☐ Month ☐☐ Year ☐☐☐☐
3. Name of medical practitioner:
4. Phone number:
5. Place of examination:
6. Stamp

7. Full names of person examined:	8. Sex: M☐ F ☐
9. Date of Birth/apparent age:	10. Age as determined scientifically
11. Next of Kin:	12. Tel. Contact:
13. Address:	

B. GENERAL HISTORY

1. Relevant medical history and medication:

C. GENERAL EXAMINATION

1. Condition of clothing:
2. Height (cm)
3. Weight:
4. Clinical findings: In every case the nature, position and extent of the abrasion, wound or other injury must be described and noted together with its probable date and manner of causation. The position of all injuries and wounds must also be noted on the sketches.
5. Mental Health and emotional status:
6. Clinical evidence of drugs or alcohol:
7. CONCLUSIONS

	Signature of Medical Practitioner

D. GYNAECOLOGICAL/OBSTETRIC HISTORY AND EXAMINATION

(State Clinical findings)

1. Age of menarche ☐ 2. Number of pregnancies ☐ 3. Number of deliveries ☐ 4. Duration of pregnanc applicable) ☐☐ weeks
5. Contraceptive use (indicate with X): Yes ☐ No 6. First date of last menstruation (LNMP):
7. Method and last date of application/ingestion: 8. Date and time of last intercourse with consent:
9. Number of consensual sexual partners during lc days: 10. Condoms Yes ☐ No ☐

11. Since the sexual assault took place, has the person (Indicate with X): Bathed ☐ washed ☐ douched ☐ showered ☐ urinated ☐ changed clothing☐
12. Breast developm Tanner stage 1-5
13. Pubic hair: tanner stage 1
14. Mons pubis:
15. Clitoris:
16. Frenulum of clitoris
17. Urethral orifice:
18. Para-urethral folds
19. Labia majora:
20. Labia minora:

21. POSTERIOR FOURCHETTE:

Scarring:
Bleeding:
Tears:
Increased friability:

22. FOSSA NAVICULARIS:

23. HYM|EN: Configuration:
24. Opening diameter (mm Transverse ☐☐ Vertical ☐☐
25. Swelling:
26. Bumps:
27. Clefts:
28. Fresh tears (position);
29. Synechiae
30. Bruising
31. VAGINA: Number of fin admitted:
Bleeding:
Tears:
Discharge:

32. CERVIX:

Erosion:
Discharge:
Bleeding:
Other:

33. PERINIUM:

Signature of Medical Practitioner:

E. ANAL EXAMINATION (State clinical findings)

SKIN SURROUNDING THE ORIFICE:

1. Hygiene
2. Pigmentation:
3. Fissures/cracks:
2. Abrasions
3. Scars:
4. Swelling/thickening:
7. Redness/erythema:
8. Bruising/haematoma
8. Tages:

ORIFICE:

9. Tears/fissures:
10. Swelling/thickening of rim (tyre sign)
11. Funnelling
13. Reflex dilatation:
34. Shortening/eversion of anal canal
35. Cupping:
16. Twitchiness/winking:
17. Discharge:

DIGITAL EXAMINATION:

18. Presence of hard faeces in rectum
19. Laxity (pressure on anal orifice):
20. Thickening of anal verge:
21. Tone (sphincter grip):

22. CONCLUSIONS:

F. MALE GENITALIA

1. Genital development:
2. Glans:
3. Testes:
4. Ulceration:
5. Presence of faeces:
6. Pubic Hair: Tanner stage 1
5. Shaft:
6. Epididymus:
7. Penile discharge:
8. Circumcision:
11. Prepuce and frenulum:
12. Scrotum:
12. Vas deferens:
13. Smegma:
14. Urethral orifice:

G. SAMPLES TAKEN FOR INVESTIGATION

Sample taken: urine sample for pregnancy test: POSITIVE ☐ NEGATIVE ☐

Seal number of evidence collection

9. SPECIMENS HANDED TO:

Name:

Rank and force number:

Signature:

10. CONCLUSIONS:

15. **CONCLUSIONS:**

Signature of medical practitione

H. TESTS DONE AND RESULTS

Tests Done	Results

I. TREATMENTS PRESCRIBED

Treatment	Yes	No	Type and Comments
STI prevention/treatment			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Post-exposure prophylaxis for HIV			
Other			

J. COUNSELLING, REFERRALS, FOLLOW-UP

General psychological status

Survivor/Victim plans to report to police OR has already made report Yes No

Survivor/Victim has a safe place to go to Has someone to accompany her/him
Yes No Yes No

Counselling provided:

Referrals

Follow-up required

Date of next visit

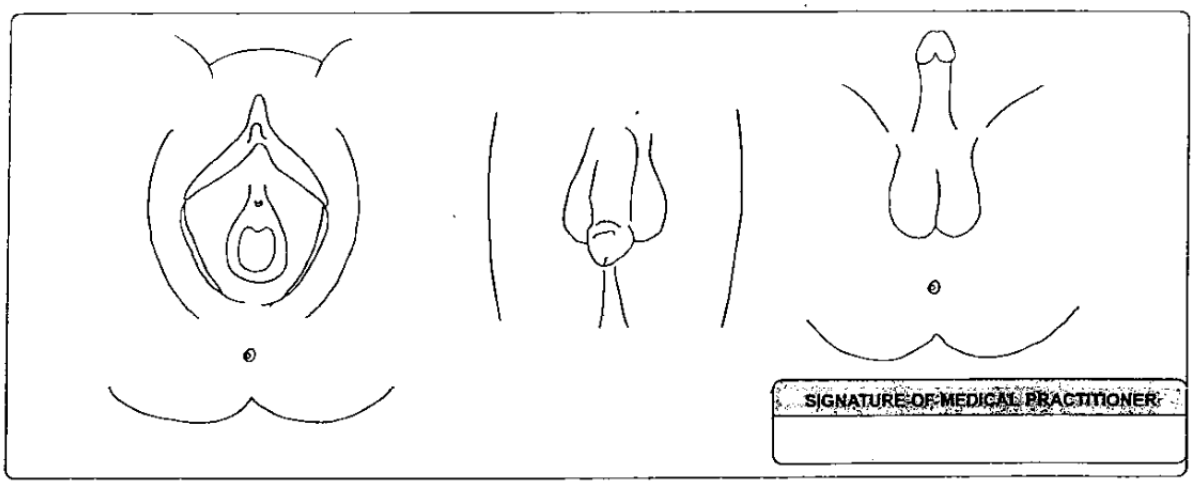
CONCLUSIONS:

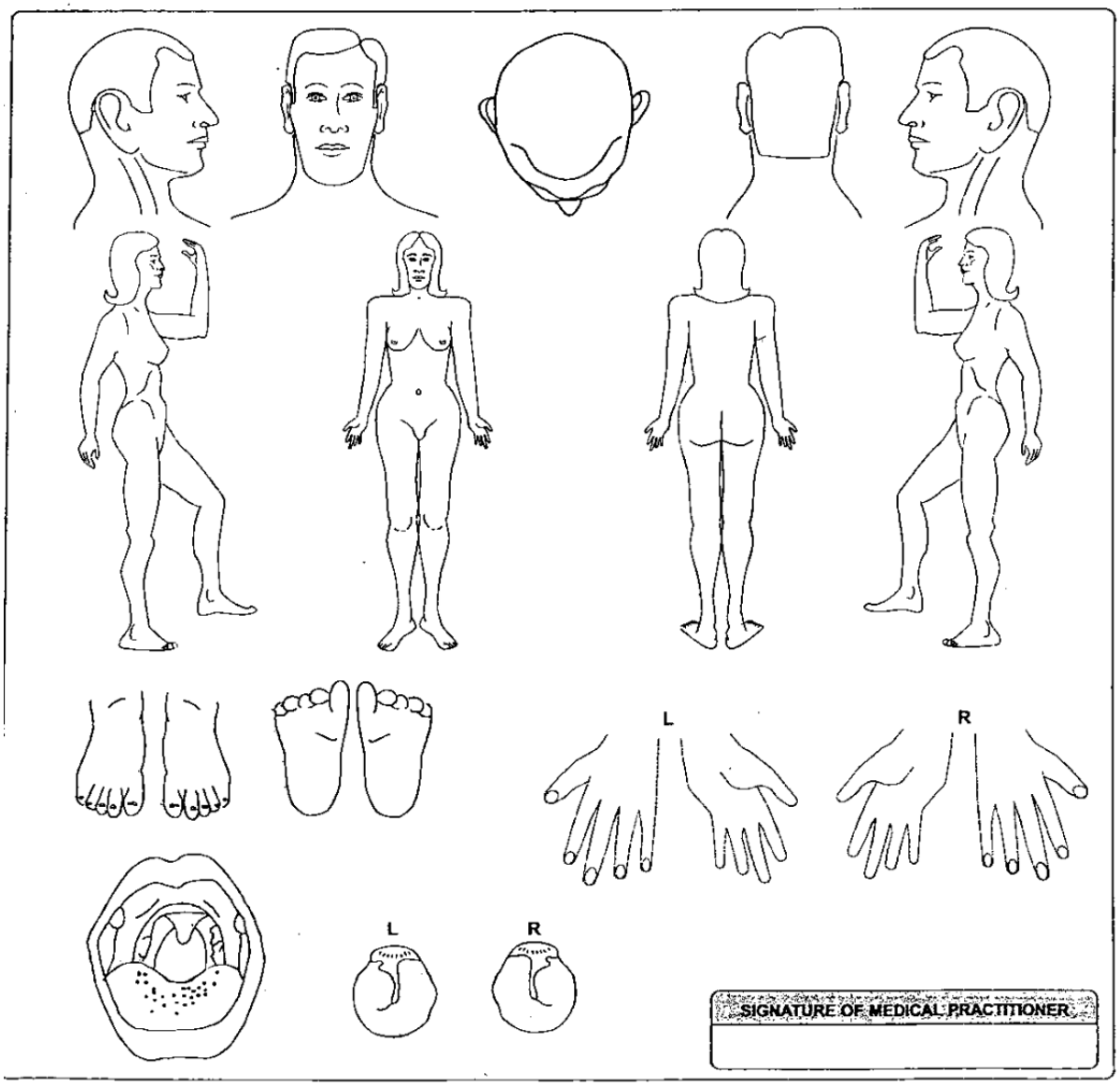
Name of health worker conducting examination/interview: _____

Title: _____ Signature: _____ Date: _____

K. MENTAL STATE

Appearance (Clothing, hair cared for or in disarray? Distracted or agitated? Restless? Signs of intoxication or misuse of drugs?)
Mood Ask: *How have you been feeling?* Also observe. For example, is she calm, crying, angry, anxious, very sad, without expression?
Speech (Silent? Speaking clearly or with difficulty? Confused ? Talking very fast or very slow?)
Thoughts Ask: *Have you had thoughts about hurting yourself?* ☐ Yes ☐ No *Are there bad thoughts or memories that keep coming back?* ☐ Yes ☐ No *Are you seeing the event over and over in your mind?* ☐ Yes ☐ No


SIGNATURE OF MEDICAL PRACTITIONER


L
R
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SIGNATURE OF MEDICAL PRACTITIONER

Annex 4: Sample of the filled medical history and examination form

REPORT BY AUTHORISED MEDICAL PRACTITIONER ON THE COMPLETION OF A MEDICO-LEGAL EXAMINATION [1]

To be completed in legible handwriting and signed on every page

A. DEMOGRAPHIC INFORMATION

1. Police station:	2. CAS No.:	3. Investigating officer: Name and number:	4. Time / Day / Month / Year
KHAYELITSHA	215/05/2005	INSP. SWEETI (0516809)	17:00 / 21 / 05 / 2005

5. Name of medical practitioner: DR. F. FRANTZ
6. Registered qualifications: BSc. MB. ChB. Fam MED. MRCP ACLS
7. Phone number: 021- 392 5154
8. Fax number: - 021. 392 5152.
9. Place of examination: KHAYELITSHA COMMUNITY HEALTH CENTRE

10. Physical practice address or stamp: KHAYELITSHA COMMUNITY HEALTH CENTRE KHAYELITSHA.

11. Full names of person examined: HELEN KHANE
12. Gender: M ☐ F ☑
13. Date of birth/apparent age: 18 YRS

B. GENERAL HISTORY

1. Revelant medical history and medication:
EPILEPTIC - ON MEDICATION - COMPLIANT WITH MEDS.

C. GENERAL EXAMINATION

1. Condition of clothing: DIRT MARKS on knee area of her jeans. Loss of some buttons (upper 2 buttons) of LS blouse
Blood: Stains on (B) chest of

2. Height (cm): 1.58
3. Mass: 55 kg.
4. General body build: BP 120/80 Jacket chest - (N) abd: soft + Non tender (CNS: N) (CVS = N) (ENT = N)

5. Clinical findings: In every case the nature, position and extent of the abrasion, wound or other injury must be described and noted together with its probable date and manner of causation. The position of all injuries and wounds must also be noted on the sketches.

Allegedly assaulted (hit with a fist) and raped by one known man on 21.05.2005 at 13h00 at 13 Qunu Str, Khayelitsha. (Residence of accused) - and back.

(History given by Helen Khane)

Clinical findings See pages (2) : (3) + (4)

6. Mental health and emotional status:
Calm.

7. Clinical evidence of drugs or alcohol:
No evidence

8. ~~CONCLUSIONS~~
Accompanied by her mother, Jane KHANE

Signature of medical practitioner

D. HISTORY IN CASE OF ALLEGED SEXUAL OFFENCE [2]

1. Age of menarche: 13 | 2. Number of pregnancies: 01 | 3. Number of deliveries: 01 | 4. Duration of pregnancy (if applicable): ___ weeks

5. Contraception (indicate with X): Yes [✓] No [ ] | 7. First date of last menstruation: 28 - 01 - 2008

6. Method and last date of application/ingestion: Depo Provera (18/03/2008) | Duration of period: 04 | 9. Duration of cycle: 28

10. Date and time of last intercourse with consent: ± 3 weeks ago. | 11. Number of consensual sexual partners during last 7 days: None | 12. Condoms: Yes [✓] No [ ]

13. Since the alleged offence took place, has the person (indicate with X): bathed [ ] washed [ ] douched [ ] showered [ ] urinated [ ] changed clothing [ ]

E. GYNAECOLOGICAL EXAMINATION (State clinical findings)

1. Breast development: Tanner stage 1–5: 5 | 2. Pubic hair: Tanner stage 1–5: 5 | 3. Mons pubis: Normal

4. Clitoris: Normal. | 5. Frenulum of clitoris: Normal.

6. Urethral orifice: Normal. | 7. Para-urethral folds: Bruise noted (See (B) - page (2))

8. Labia majora: Normal | 9. Labia minora: Normal.

10. Posterior fourchette: scarring: NO | bleeding: NO | tears: NO | increased friability: No.

11. Fossa navicularis: Normal.

12. Hymen: configuration: annular | 13. Opening diameter (mm): Transverse: 13 | Vertical: 13

14. Swelling: NO | 15. Bumps: NO | 16. Clefts: No

17. Fresh tears (position): No | 18. Synechiae: No | 19. Bruising: No.

20. Vagina: Number of fingers admitted: x 2. | bleeding: No | discharge: Mucoid | tears: No.

21. Cervix: erosion: No | bleeding: No | discharge: NO. | other:

22. Perineum: Normal.

F. SAMPLES TAKEN FOR INVESTIGATION

1. Forensic specimens taken: Urine sample for pregnancy test: Positive [ ] Negative [✓] | Seal number of Evidence Collection Kit: AK 023 541

2. Specimens handed to: Name: Insp. Sumari | Rank and Force number: (0516809). | Signature:

3. CONCLUSIONS

Bruise
Trauma.
Possible.
Scalp HAIR
Pubic HAIR.
Perineal Swabs.
Nail Swabs.

Prophylaxis:
STD & HIV - at Kharaliuka Comm. Centre
Follow up Kharaliuka comm. centre.
Kyaka. Repeat
Kharaliuka Comm. Hea

Signature of medical practitioner

G. ANAL EXAMINATION (State clinical findings) 3

SKIN SURROUNDING THE ORIFICE

1. Hygiene:
2. Pigmentation:
3. Fissures/cracks:
4. Abrasions:
5. Scars:
6. Swelling/thickening:
7. Redness/erythema:
8. Bruising/haematoma:
9. Tags:

ORIFICE

10. Tears/fissures:
11. Swelling/thickening of rim (tyre sign):
12. Funnelling:
13. Reflex dilatation:
14. Shortening/eversion of anal canal:
15. Cupping:
16. Twitchiness/winking:
17. Discharge:

DIGITAL EXAMINATION

18. Presence of hard faeces in rectum:
19. Laxity (pressure on anal orifice):
20. Thickening of anal verge:
21. Tone (sphincter grip):

22. CONCLUSIONS

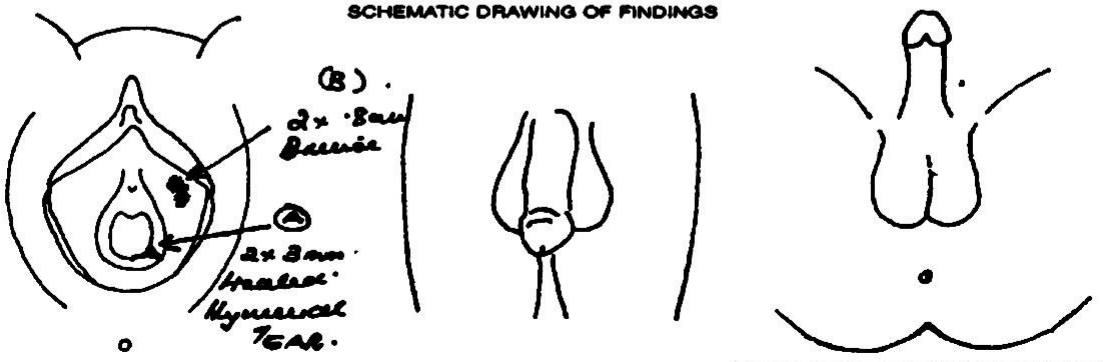
No abnormality noted.

H. MALE GENITALIA

1. Genital development: Tanner stage 1–5 ☐
2. Glans:
3. Testes:
4. Ulceration:
5. Presence of faeces:
6. Pubic hair: Tanner stage 1–5: ☐
7. Shaft:
8. Epididymus:
9. Penile discharge:
10. Circumcision:
11. Prepuce and frenulum:
12. Scrotum:
13. Vas deferens:
14. Smegma:
15. Urethral orifice:

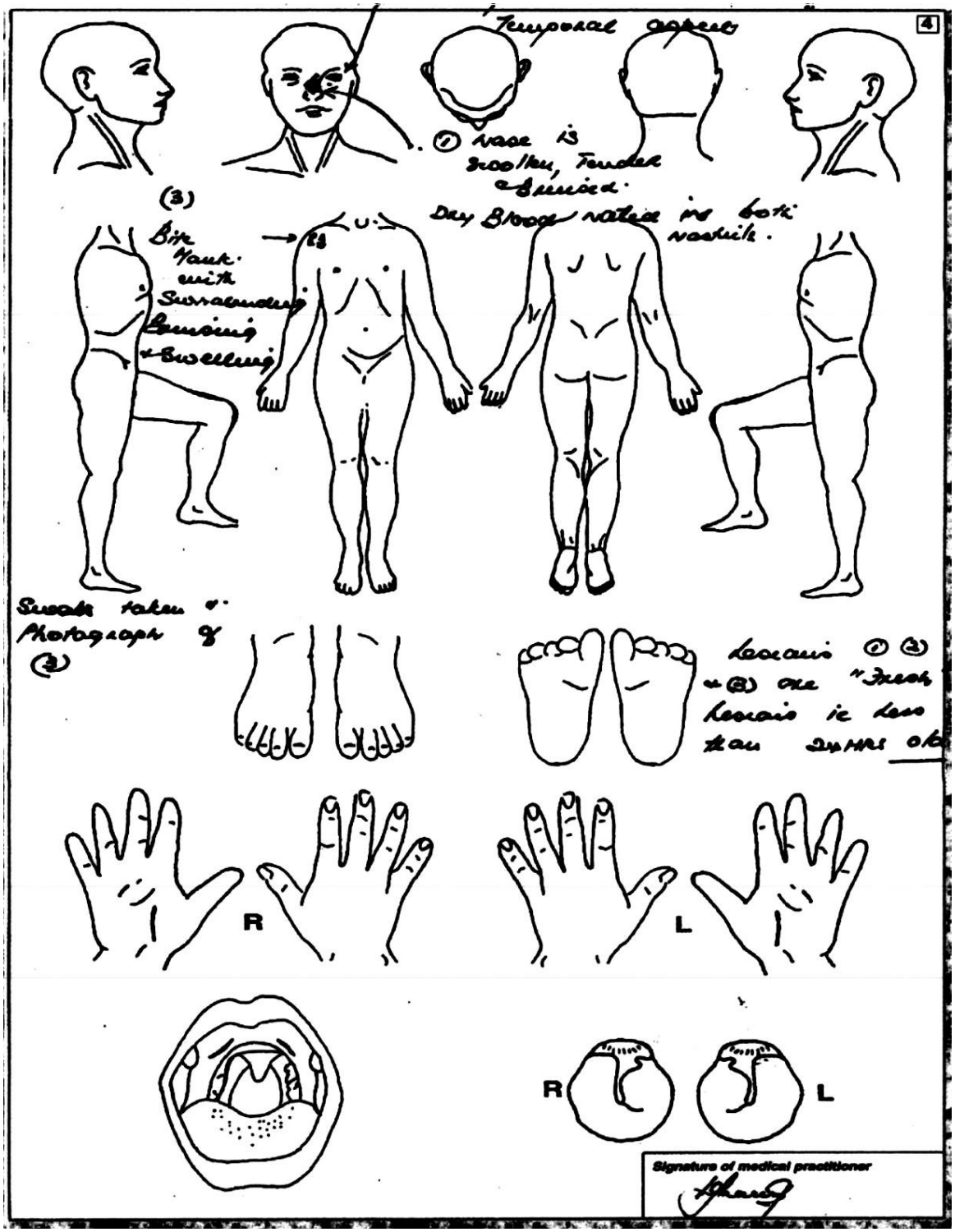
16. CONCLUSIONS

SCHEMATIC DRAWING OF FINDINGS



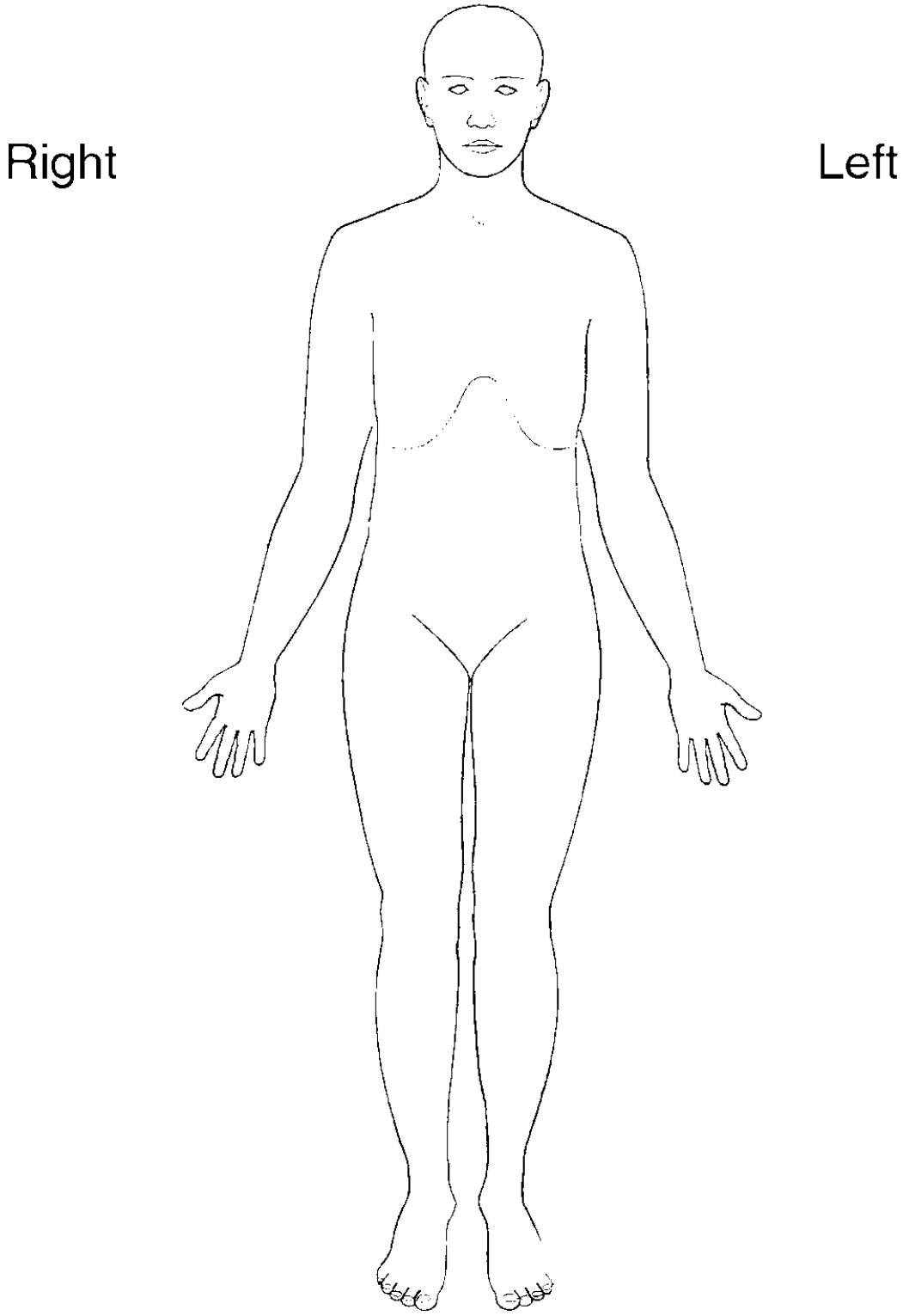
Lesion (A) is a Lesion

Signature of medical practitioner

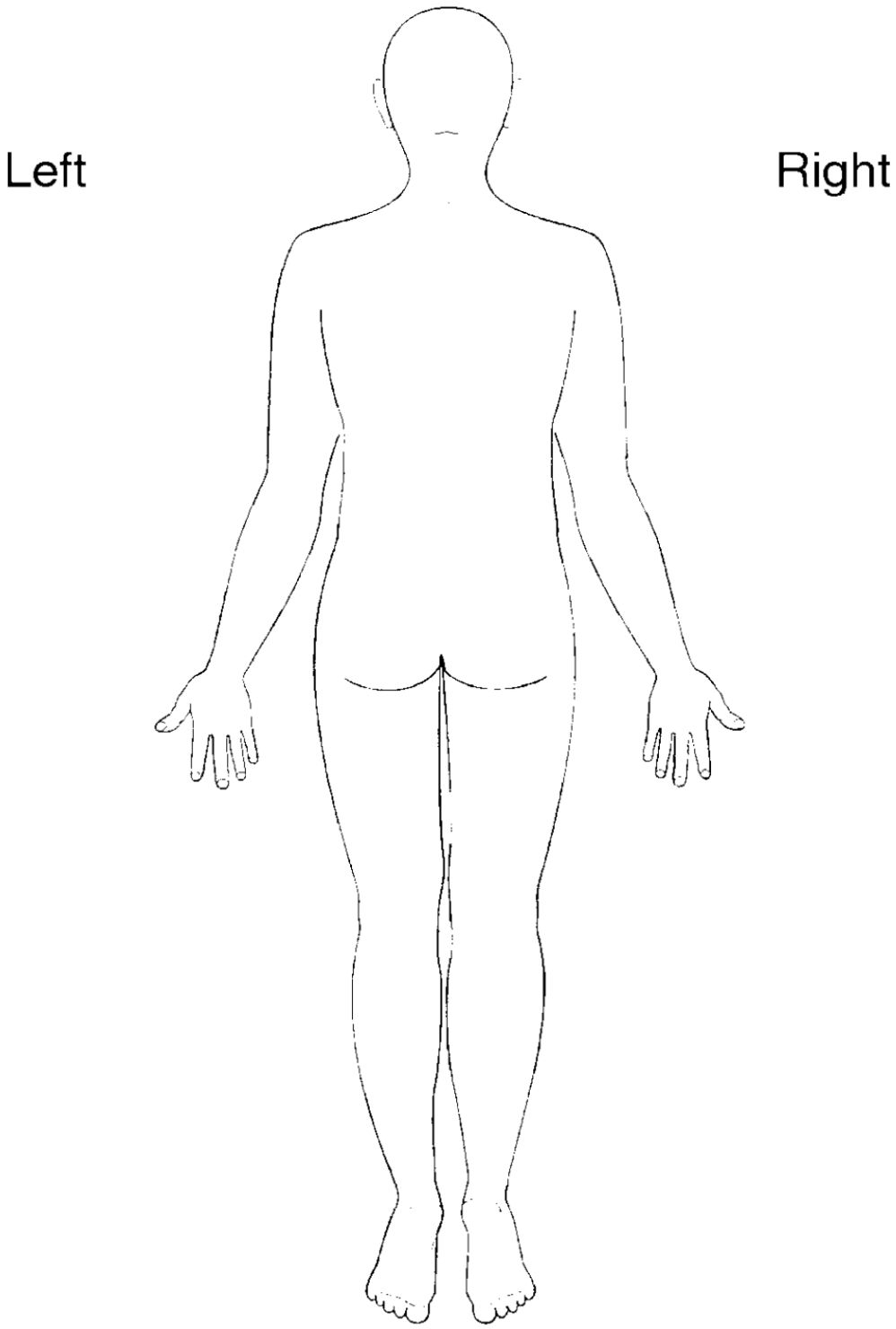

Temporal aspect
4
(1) Face is
(3)
Bite
mark
with
Surrounding
Bruising
+ Swelling
Dry Blood
Swab taken &
Photograph
(2)
R
L
R
L
Signature of medical practitioner

Annex 5: Pictograms

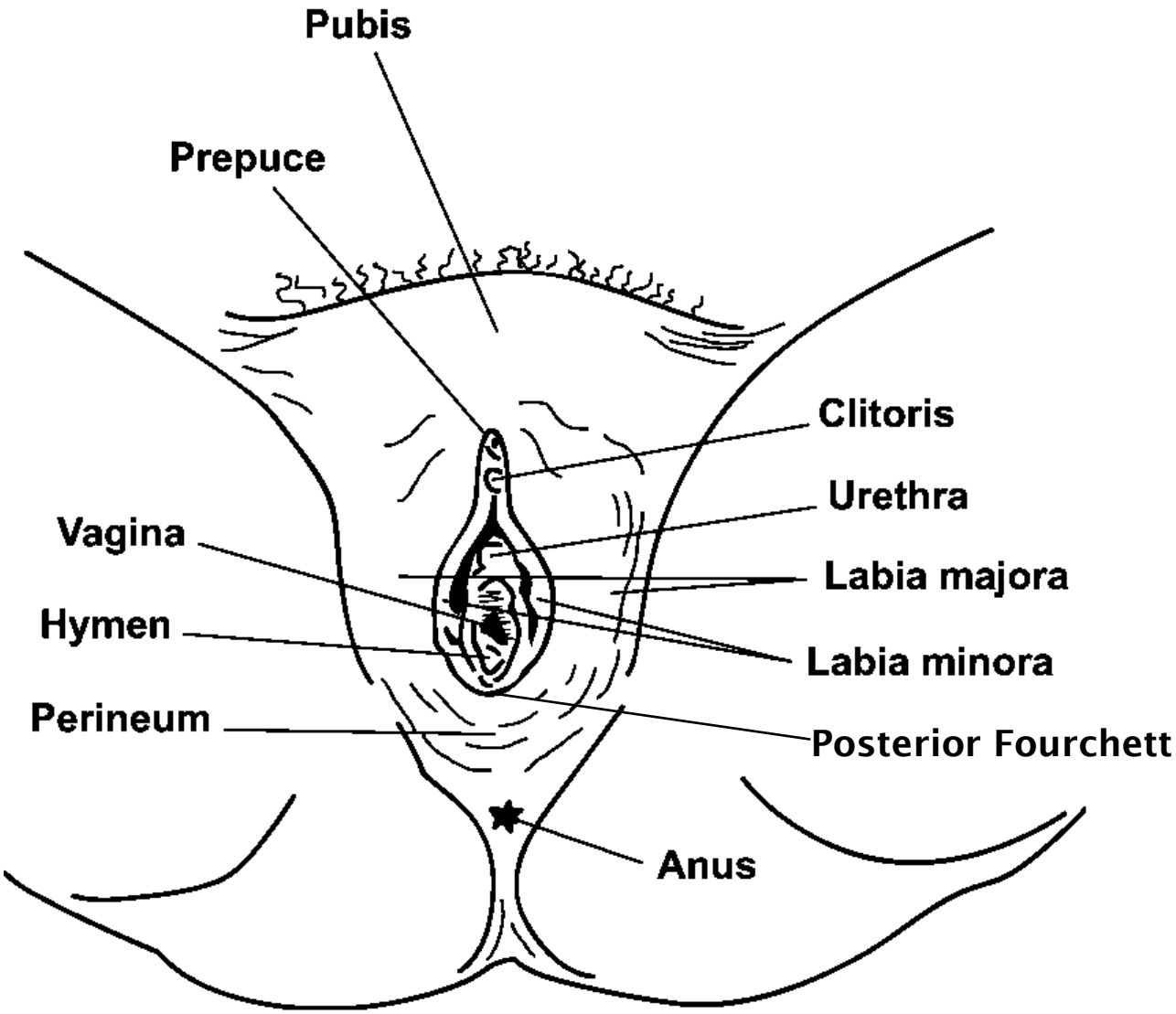
FRONT OF A PERSON



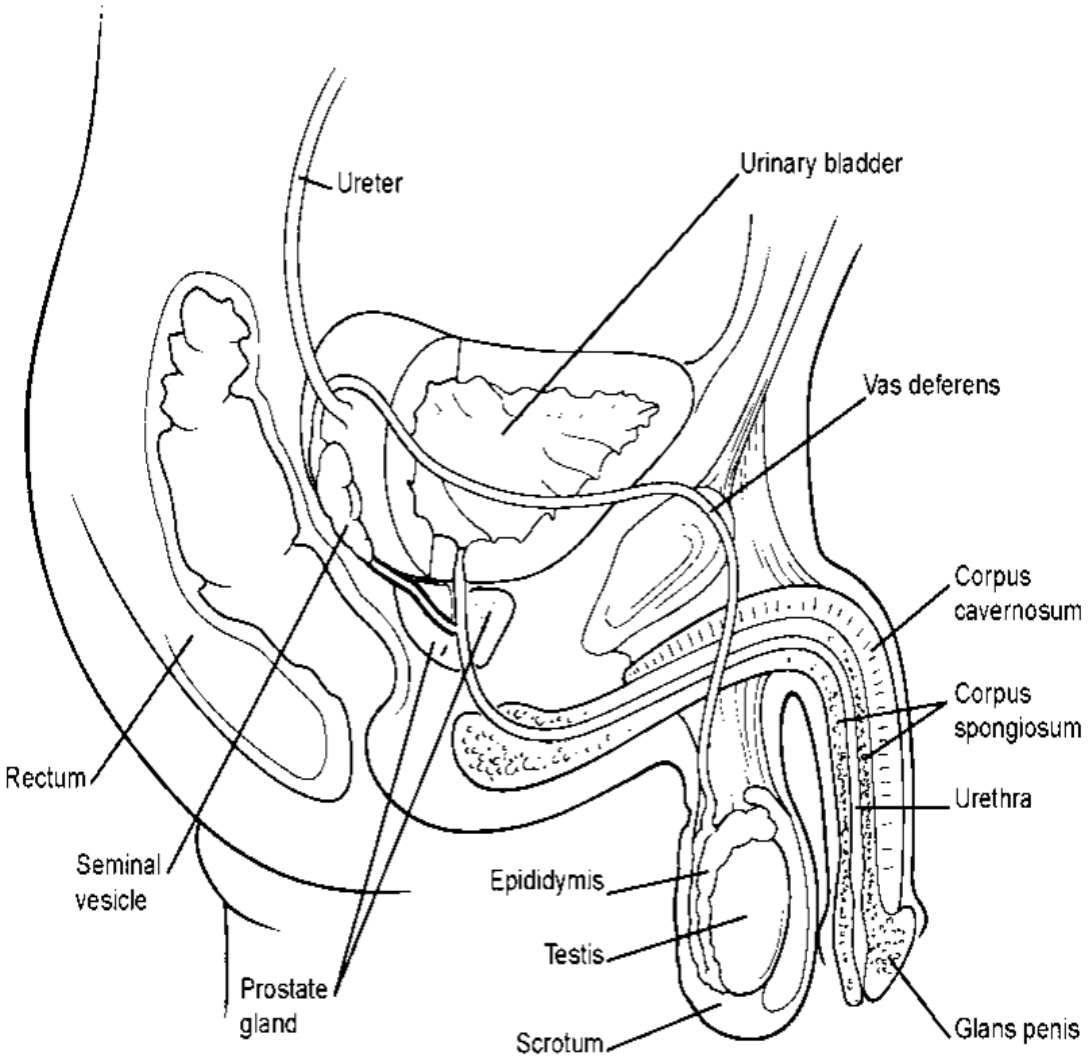
BACK OF A PATIENT



FEMALE EXTERNAL GENITALIA



Male Reproductive Organs enlarged to show detail



Annex 6: List of relevant reagents/equipment/supplies that are required for a laboratory offering S/GBV and VAC services

TYPE OF SUPPLIES OR TEST	REAGENT/EQUIPMENT/SUPPLY & SPECIFICATIONS
General requirements/ supplies	Laboratory containers for transporting swabs Paper tape for sealing and labelling containers/bags Cotton(rolls) Cover slips Hand sanitizers Pasteur pipettes Needle prickers Zip lock bags Sterile urine containers Vacutainer for collecting blood Vacutainer needle holders Vacutainer needles Syringes Butterfly needles for children Photographic equipment, both still and video Colposcope (The Colposcope is an important asset in the identification of microscopic trauma) Autoclave Microscope (10X40X100)
Supplies for universal precautions	Powder free Gloves Box for safe disposal of contaminated materials and sharps (Black, Yellow, Red) Soap
HIV test	Determine with Buffer Statpak with Buffer Unigold with Buffer DBS kits
Pregnancy test	Pregnancy Test Cassette/ Pregnancy Test strip Boric Acid

STI testing	RPR/ VDRL strips
	TPHA Strips
Syphilis	RPR Carbon reagent/ VDRL reagents
	Needle prickers
	Laboratory shaker
Gonorrhoea	Uri-strips (10 parameters)
	Methanol
	Microscope slides
	Gonorrhoea test strips
	Gram stains
Chlamydia	Gram stains
	Chlamydia test strips
Hepatitis B	Hepatitis B strips
	ELISA
Trichomonas	Vaginal swabs
	Microscope slides
Spermatozoa microscopy	Sterile swabs
	Glass slides for preparing wet and/or dry mounts (for sperm) /Frosted Slides
	Specimen containers
	Acid phosphatase
	Saline suspension
	Applicators for collecting samples
	Gauze compresses for collecting samples
	Toluidine blue dye (used to assist in highlighting observed genital and perianal injuries)
	Alcohol swabs
	Deionized sterile water
	Pencil

Annex 7: Medical Certificates

THE REPUBLIC OF UGANDA

SEXUAL AND GENDER BASED VIOLENCE MEDICAL CERTIFICATE FOR A CHILD

I, the undersigned: (NAME, first name)

Title:

on this date: (day-month-year,) ……/…..…/……..…time

certify having examined at the request of:

(name of father, mother, legal representative, caretaker)

child: (name)

date of birth: (day, month, year) ……/ ……../

address: (exact address of the parents or place of residence of the child)

During the meeting, the child told me: (repeat the child's own words as closely as possible)

During the meeting, (name of the person accompanying the child) **stated:**

This child presents the following signs:

General examination: (child's behaviour: prostrate, excited, calm, fearful, mute, crying, etc.)

Physical examination: (detailed description of lesions, the site, extent, pre-existing or recent, severity)

During the genital examination: (signs of recent or previous defloration, bruises, tears, etc.)

During the anal examination:

Other examinations carried out and samples taken:

The absence of lesions should not lead to the conclusion that no sexual attack took place.

The medical care and treatment provided

……..

Certificate prepared on this day and handed over to (Name, first name of father, mother, legal representative) **as proof of evidence.**

Signature of the health worker

THE REPUBLIC OF UGANDA

SEXUAL AND GENDER BASED VIOLENCE MEDICAL CERTIFICATE FOR AN ADULT

I, the undersigned: (NAME, first name)
title: (Indicate the function)
on this date: (day-month-year,) ……/…..…/……..…time
certify having examined at his/her request Mr, Mrs, Miss: (NAME, first name)

date of birth: (day, month, year) ……/ ……../
address: (exact address of the person examined)

She/He declared that she/he was the victim of a sexual attack on: (time, day, month, year)

at: (place)
by: (known or unknown person)
Ms, Mrs, Miss, Mr _____ **presents the following signs:**
General examination (behaviour: prostrate, excited, calm, afraid, mute, crying, etc.)

Physical examination: (detailed description of lesions, the site, extent, pre-existing or recent, severity)

Genital examination: (signs of recent or previous defloration (recent rupture of membranes), bruises, abrasions, tears, etc.)

Anal examination:

Other examinations carried out and samples taken:

Evaluation of the risk of pregnancy:

The absence of lesions should not lead to the conclusion that no sexual attack took place.

The medical care and treatment provided

Certificate prepared on this day and handed over to the person concerned as proof of evidence.

Signature of the health worker

Annex 8: Protocols for prevention and treatment of STIs

Based on WHO-recommended STI treatments for adults (may also be used for prophylaxis)

Note: These are examples of treatments for sexually transmitted infections. There may be other treatment options. The options below are based on the Uganda 2012 STI treatment guidelines.

STI	TREATMENT	
Gonorrhoea	Ciprofloxacin	500 mg orally, single dose (*contraindicated in pregnancy)*
	Cefixime	*Or* 400 mg orally, single dose
	Ceftriaxone	Or 125mg intramuscularly, single dose
Chlamydial infection	Azithromycin	1g orally, in a single dose (*not recommended in pregnancy)*
	Doxycycline	*Or* 100mg orally, twice daily for 7 days (*contraindicated in pregnancy)*
Chlamydial infection in pregnant woman	Erythromycin	500mg orally, 4 times daily for 7 days
		Or
	Amoxicillin	500mg orally, 3 times daily for 7 days
Syphilis	Benzathine Benzylpenicillin	2.4 million IU, intramuscularly, once only (give as two injections in separate sites)
Syphilis, patient allergic to penicillin	Doxycline	100mg orally, twice daily for 14 days (*contraindicated in pregnancy)* (*Note: this antibiotic is also active against Chlamydia)*
Syphilis in pregnant women allergic to penicillin	Erythromycin	500mg orally, 4 times daily for 14 days *(Note: this antibiotic is also active against Chlamydia)*
Trichomoniasis	Metronidazole	2g orally, in a single dose or as two divided doses at a 12-hour interval (*contraindicated in the first trimester of pregnancy)*

Note: benzathine benzybenicillin may be omitted if the prophylactic treatment regimen includes azithromycin 1g orally, in a single dose, which is effective against incubating syphilis.

Give one easy-to-take, short treatment for each of the infections that are prevalent in your setting.

Example:

Presumptive treatment for gonorrhoea, syphilis and chlamydial infection for a woman who is not pregnant and not allergic to penicillin:

- Cefixime 400mg orally + azithromycin 1g orally, single dose; OR
- Ciproflaxicin 500mg orally + benzathine benzylpenicillin 2.4IU intramuscularly + doxycline 100mg orally, twice daily for 7 days.-

If trichomoniasis is prevalent, add a single dose of 2g of metronidazole orally.

WHO-recommended STI treatments for children and adolescents (may also be used for presumptive treatment)

Note: These are examples of treatments for sexually transmitted infections. There may be other treatment options. The options below are based on the Uganda 2012 treatment guidelines and other treatment protocols.

STI	Weight	TREATMENT	
Gonorrhoea	<45kg	Ceftriaxone	125mg intramuscularly, single dose
			Or
		Spectinomycin	40mg/kg of body weight, intramuscularly (up to a maximum of 2g) single dose
		Cefixime	*Or (if > 6 months)* 8 mg/kg of body weight orally, single dose
	≥ 45kg		Treat according to adult protocol
Chlamydial infection	<45kg	Azithromycin	20mg/kg orally, single dose
			Or
		Erythromycin	50mg/kg of body weight daily, orally (up to a maximum of 2g), divided into 4 doses, for 7 days
	≥ 45kg but <12 years	Erythromycin	500mg orally, 4 times daily for 7 days
			Or
		Azithromycin	1g orally, single dose
	≤ 12 year		Treat according to adult protocol
Syphilis		Benzathine Benzylpenicillin	50,000IU/kg intramasuscularly (up to a maximum of 2.4 million IU) single dose
Syphilis, patient allergic to		Erythromycin	50mg/kg of body weight daily, orally (up to a maximum of 2g), divided into 4 doses, for 14 days

penicillin			
Trichomoniasis	< 12 year	Metronidazole	5mg/kg of body weight orally, 3 times daily for 7 days
	≥ 12 year		Treat according to adult protocol

Note: benzathine benzybenicillin may be omitted if the prophylactic treatment regimen includes azithromycin 1g orally, in a single dose, which is effective against incubating syphilis.

Annex 9: Guidelines to Provision of Emergency Contraception

Introduction:

Many women and girls in Uganda who become victims of rape or unprotected sex end up having unwanted pregnancy. This forces them to have abortions which in most cases is unsafe and can lead to death of the mother. The Ministry of Health in collaboration with partners recommends use of Emergency contraception to prevent unwanted pregnancies and hence reduce on the number of women dying due to unsafe abortions resulting from unwanted pregnancies.

Facts about viability of sperm and ovum

How long can semen survive outside the body?

The answer depends on a number of factors, the most important of which is where the sperm are located. On a dry surface, such as clothing or bedding, sperm are dead by the time the semen has dried. In water, such as a warm bath or hot tub, sperm will likely live longer because they thrive in warm, wet environments; however, the chances sperm in a tub of water will find their way inside a female bather and cause her to become pregnant are extremely low.

Inside a woman's body, sperm can live for up to five days depending on the conditions. If you have unprotected sex even a few days before your partner ovulates, there is a chance of achieving a pregnancy.

After ovulation how long does the egg stay viable?

After ovulation, if fertilization does not occur the egg dissolves after 48 hours.You ovulate once a month but you have a window of around three days to get pregnant because the sperm lives for upto 5 days. You have a few days of high fertility then one day of peak fertility.

What is Emergency Contraception?

Emergency contraception refers to methods of contraception used by women to prevent unintended pregnancy following unprotected sexual intercourse. *These methods include use of dedicated products like Postnor and normal birth control pills.* It should not be used as a routine contraceptive method.

Why Emergency Contraception?

- EC prevents pregnancy after unprotected sexual intercourse e.g. after rape, incest etc.

- EC has the potential of preventing unwanted pregnancy which usually end up in unsafe abortions, infanticide, child neglect and abandonment. Unsafe abortions are one of the major causes of maternal deaths in Uganda.

When is Emergency Contraception needed?

No contraception is 100 percent effective and few couples can use their methods appropriately every time they have intercourse. Emergency contraception provides an important safety net:

- After a woman has had sex without any contraceptive protection (unprotected sexual intercourse).
- When a woman has been raped(forced to have intercourse)
- When a condom breaks or slips during intercourse
- When an Intra Uterine Device has been displaced
- When a woman has miscalculated her fertile period, when using natural family planning
- When a woman has forgotten to take oral contraceptives for 2 consecutive days
- When a woman is more than four weeks late for her injectable contraceptive
- As soon as a woman on ARVs realizes that she has missed taking her contraceptive.

Types of Emergency Contraception:

There are two methods of emergency contraception:

1. Emergency contraceptive pills
2. Intra Uterine Device

Emergency Contraceptive pills (ECP):

These are hormonal methods that can be used to prevent pregnancy following unprotected sexual intercourse. The contents of ECP are the same as the regular oral contraceptive pills but differ in dosage. Oral contraceptive pills can also be used as ECP as indicated in Table A. Alternatively, emergency contraceptive pills are also available as a dedicated product under several brand names e.g. Vikela, Norlevo, PC4, Postinor-2 or Levonelle-2.

Types of emergency contraceptive pills:

Combined pills: These are oral contraceptives containing hormones, estrogen and progestin. Each dose contains 0.1 mg estrogen and 0.50 mg of progestin. The combined Oral contraceptives (COCs) normally called the Yuzpe regimen when used for EC prevents about 75% of the expected pregnancies.

Progestin - only pills (POPs): These are slightly more effective than the combined pill

regimen and cause fewer side effects. Each dose contains 0.75mg levonorgestrel (a progestin). This regimen prevents about 89% of the expected pregnancies.

Vikela (Postinor): This is specifically produced for emergency contraception. Each dose contains 0.75 mg Levonogestrel

FORMULATION AND DOSES FOR EMERGENCY CONTRACEPTION USING ORAL CONTRACEPTIVE PILLS.

	Common Brand Names	Formulation per tablet/pill	Tablet(s) required per dose	Doses	Timing of administration
Combined Pill regimen	▪ Microgynon ▪ Lo-feminol 2 Pilplan	EE0.03mg+ LNG0.15mg EE0.03mg+ NG0.3mg	4 4	2 2	First dose within 120 hours (5 days) after unprotected sex Second dose 12 hours later.
Progestrone Only regimen	▪ Microval ▪ Ovrette	LNG0.03mg NG0.0375mg	25 20	2 2	
Dedicated ECP	▪ Vikella ▪ Postinor-2	LNG 0.75mg LNG 0.75 mg	1 1	2 2	

NB: EE===Ethinylestradiol

LNG===Levonorgestrel

NG====Norgestrel

Characteristics of Emergency Contraceptive pills:

- Safe, effective and easy to use by all women.
- Needs to start within 120 hours (5 days) after unprotected sexual intercourse. The sooner the first pill is taken after unprotected intercourse, the more effective it will be. The second pill should be taken 12 hours after first.
- Can be used anytime during the menstrual cycle.
- Not to be used as a regular method, only to be used in an emergency. This is because ECPs are less effective and have more side effects than other family planning methods such as condoms, oral and injectable contraceptives.
- Do not protect against STIs including HIV.

- Will not work once a woman is pregnant. Therefore, women who are already pregnant should not take ECP.

Note:ECP will not harm the foetus and will not end an established pregnancy since the hormones in it just stabilise the pregnancy.

Mechanisms of Action

There are many ways ECPs may work depending on the time in the menstrual cycle when intercourse occurred and when ECP was taken. ECP works like the IUD and oral contraceptive pills. **ECPs do not interrupt an established pregnancy and thus do not cause abortion** but may:

- Inhibit or delay ovulation - altering transport of sperm or ovum
- Slow down the movement of sperms to reach the egg.

However, it is not clear which action will be predominant to anyone individual.

Side Effects:

Some few people the main side effects of ECPs are nausea and vomiting. Some few people may experience headache, spotting, vaginal bleeding, dizziness and fatigue. These side effects do not generally last more than 24 hours after taking the second dose. ECPs can also cause the next menstrual period to begin a few days earlier or later than expected. If the menstrual period is more than one week than expected, the client may be pregnant.

Continuing with regular contraception after taking emergency contraceptive pills (ECPs)

- She can start injectables on the same day as the ECPs, or if preferred, within 7 days after the start of her monthly bleeding. She will need a backup method for the first 7 days after the injection. She should return if she has signs or symptoms of pregnancy other than not having monthly bleeding (see p. 371 for common signs and symptoms of pregnancy)

Use of an intrauterine device (IUD) as an emergency contraceptive

- If the survivor/Victim presents within five days after rape (and if there was no earlier unprotected sexual act in this menstrual cycle), insertion of a copper-bearing IUD is an effective method of emergency contraception. It will prevent more than 99% of expected subsequent pregnancies.
- Women should be offered counselling on this service so as to reach an informed decision.
- A skilled provider should counsel the patient and insert the IUD. If an IUD is inserted, make sure to give full STI treatment, as recommended in Annex 9.

- The IUD may be removed at the time of the woman's next menstrual period or left in place for future contraception.

Characteristics of IUDs as Emergency Contraception

- Can be used as an ongoing contraceptive for women who wish to leave the IUD in place.
- Insertion in parous women (those who have at least one child) is easier
- Insertion in nulliparous women (those that have not had any children) may cause a bit of discomfort.
- Do not protect against STIs, including HIV.

Mechanisms of Action:

The IUDs act by:

- Preventing fertilization
- Decreasing the number of sperm reaching the fallopian tube
- Reducing the mobility of sperm (makes it hard for sperm to move)
- Can prevent a fertilized egg from being implanted in the wall of the uterus.

IUDs can disrupt an established pregnancy and should therefore not be used when the pregnancy is established.

Side Effects

Some users report the following:

- Changes in bleeding patterns (especially in the first 3 to 6 months) including:
  - Prolonged and heavy monthly bleeding
  - Irregular bleeding
  - More cramps and pain during monthly bleeding

Limitations of ECPs

- Not used as a regular family planning method
- Should not be used as back up to long-term contraceptive options
- No protection against HIV/AIDS/STIs
- Once pregnant EC will not help you

However ECPs do not protect against STDs/HIV/AIDs. The correct and constant use of condoms is recommended either alone or with another contraceptive method. Condoms are proven to protect against STIs and HIV/AIDs.

Questions and Answers about Emergency Contraceptive Pills

1. Do ECPs disrupt an existing pregnancy?

No. ECPs do not work if a woman is already pregnant. When taken before a woman has ovulated, ECPs prevent the release of an egg from the ovary or delay its release by 5 to 7 days. By then, any sperm in the woman's reproductive tract will have died, since sperm can survive there for only about 5 days.

1. Do ECPs cause birth defects? Will the foetus be harmed if a woman accidentally takes ECPs while she is pregnant?

No. Good evidence shows that ECPs will not cause birth defects and will not otherwise harm the foetus if a woman is already pregnant when she takes ECPs or if ECPs fail to prevent pregnancy.

2. How long do ECPs protect a woman from pregnancy?

Women who take ECPs should understand that they could become pregnant the next time they have sex unless they begin to use another method of contraception at once. Because ECPs delay ovulation in some women, *she may be most fertile soon after taking ECPs.* If she wants ongoing protection from pregnancy, she must start using another contraceptive method at once.

3. What oral contraceptive pills can be used as ECPs?

Many combined (estrogen-progestin) oral contraceptives and progestin-only pills can be used as ECPs. Any pills containing the hormones used for emergency contraception—levonorgestrel, microgynon, norgestrel, and these progestins together with estrogen (ethinylestradiol)—can be used.

4. Is it safe to take 40 or 50 progestin-only pills as ECPs?

Yes. Progestin-only pills contain very small amounts of hormone. Thus, it is necessary to take many pills in order to receive the total ECPdose needed. In contrast, the ECP dosage with combined (estrogen-progestin) oral contraceptives is generally only 2 to 5 pills in each of2 doses 12 hours apart. Women should not take 40 or 50 combined (estrogen-progestin) oral contraceptive pills as ECPs.

5. Are ECPs safe for women with HIV or AIDS? Can women on antiretroviral therapy safely use ECPs?

Yes. Women with HIV, AIDS, and those on antiretroviral therapy can safely use ECPs.

6. Are ECPs safe for adolescents?

Yes. A study of ECP use among girls 13 to 16 years old found it safe. Furthermore, all of the study participants were able to use ECPs correctly.

8. Can a woman who cannot use combined (estrogen-progestin)oral contraceptives or progestin-only pills as an ongoing method still safely use ECPs?

Yes. This is because ECP treatment is very brief.

9. If ECPs failed to prevent pregnancy, does a woman have agreater chance of that pregnancy being an ectopic pregnancy?

No. To date, no evidence suggests that ECPs increase the risk of ectopic pregnancy. Worldwide studies of progestin-only ECPs, including a United States Food and Drug Administration review, have not found higher rates of ectopic pregnancy after ECPs failed than are found among pregnancies generally.

11. Why give women ECPs before they need them? Won't that discourage or otherwise affect contraceptive use?

No. Studies of women given ECPs in advance report these findings: Women who have ECPs on hand took them sooner after having unprotected sex than women who had to seek out ECPs. Taken sooner, the ECPs are more likely to be effective.

Women given ECPs ahead of time were more likely to use ECPs than women who had to go to a provider to get ECPs. Women continued to use other contraceptive methods as they did before obtaining ECPs in advance.

12. Should women use ECPs as a regular method of contraception?

No. Nearly all other contraceptive methods are more effective in preventing pregnancy. A woman who uses ECPs regularly for contraception is more likely to have an unintended pregnancy than a woman who uses another contraceptive regularly. Still, women using other methods of contraception should know about ECPs and how to obtain them if needed—for example, if a condom breaks or a woman misses 3 or more combined oral contraceptive pills.

13. If a woman buys ECPs over the counter, can she use them correctly?

Yes. Taking ECPs is simple, and medical supervision is not needed. Studies show that young and adult women find the label and instructions easy to understand. ECPs are approved for over-the counter sales or non-prescription use in many countries.

Annex 10: Protocols for post-exposure prophylaxis of HIV infections

NB: Service providers should always look out for the current protocols

Scientific evidence shows that ARVs are effective in preventing HIV transmission following occupational exposures and mother-to-child transmission. Starting PEP as soon as possible (within 2-72 hours) following sexual violence has benefits to the affected individual. This was the basis for the development of Post Exposure Prophylaxis Policy Guidelines by the Ministry of Health. Currently PEP for survivor/Victim s of sexual violence is available in all government hospitals, Health Centre IVs and some Health Centre IIIs.

Provision of Post Exposure Prophylaxis to the survivor/Victim s of sexual violence takes priority over any other intervention unless the survivor/Victim has severe injuries such as vaginal or anal tears and is bleeding profusely. In such case attendance to the injuries takes priority. Even then, the survivor/Victim should be started on ARVs where possible. It is important to remember that PEP in sexual exposure is a reserve for rape and defilement only and not for casual/consensual sex exposures that may include incidents where the perpetuator is HIV negative while the survivor/Victim is HIV positive.

Before starting PEP services, it is crucial that all staffs are aware of the indications for PEP and trained in counselling survivor/Victim on PEP service provision. It is also important that a lists of provider names including psychosocial support providers and their addresses and telephone contacts are compiled and disseminated to key stakeholders.

Use the most current available ARVs according to what is available.

- Gastrointestinal side-effects may occur in up to 50% of people taking ZDV/3TC, but they are relatively minor. Appropriate counselling will help people take the full treatment. There are no contraindications to starting PEP on the same day as emergency contraception and STI prophylaxis, although the doses should be spread out, and if possible taken with food, to reduce side-effects, such as nausea.
- Our policy demands an HIV Test for the survivor/Victim as a must. In fact, if an HIV test is refused, PEP should be denied. This is because in the event that the survivor/Victim is also HIV positive, the possibility of resistance developing is very high (after a short course).
- Survivor/Victim s who are known or found to be HIV-positive should not be offered PEP. While it is not likely to do harm, there is no expected benefit. Such people should be appropriately counselled and referred to special programmes for

people living with HIV/AIDS (PLHA), such as home-based care, supplementary feeding, and treatment of opportunistic infections.

- Pregnancy is not a contraindication to PEP, and it should be prescribed to pregnant women in the same manner as to non-pregnant women. Women who are less than 12 weeks pregnant should be informed that the possible effects of the drug on the foetus are not known. (Ensure that pregnant women are referred for appropriate antenatal care.)

HIV Post-Exposure Prophylaxis in sexual exposures

Post Exposure Prophylaxis policy guidelines and protocols have been developed to address the issue of exposures of health providers to HIV and other blood borne pathogens. The guidelines take into consideration other providers outside the health sector and survivor/Victim s of sexual assault.

PEP provision to the survivor/Victim of sexual violence takes priority over any other intervention unless the survivor/Victim has severe injuries such as vaginal or anal tears and is bleeding profusely. In such case attendance to the injuries takes priority. Health facilities that are not in position to attend to such injuries should refer the survivor/Victim immediately to a hospital but having given the start dose of PEP because it is more effective when taken within 2-72 hours. It is important to remember that PEP in sexual exposure is a reserve for **rape** and **defilement** only and not for casual sex exposures.

Points to consider before providing ARVs for PEP

- PEP Policy Guidelines require an HIV Test for the survivor/Victim for PEP to be provided. Should the survivor/Victim refuse to have an HIV Test, s/he should not get ARVs for PEP because in the event that the survivor/Victim may already be HIV positive, the possibility of developing resistance to the ARVs after a short course may be high. Moreover, the PEP will not benefit the survivor/Victim since it is meant to prevent development of HIV/AIDS after an exposure.
- Survivor/Victim s who are known or found to be HIV-positive should not be offered PEP. Such people should be appropriately counselled and referred to special programmes for people living with HIV/AIDS (PLHA), such as home-based care, supplementary feeding, and treatment of opportunistic infections.
- While providing PEP, it is important that the most current available ARVs are used according to first line and second line drug regimens.

- Pregnancy is not a contraindication to PEP. However, the provider should bear in mind that some ARVs such as Effavirenz and Didanosine have teratogenic effects to the foetus and should be avoided in pregnancy.
- While providing PEP for pregnant women, the provider should weigh the risks of PEP against risks of developing HIV following exposure. If the latter outweighs the former, the woman should be given PEP. If the risks of the former outweigh those

of the latter, then PEP may be withheld from the woman. Pregnant women who are less than 12 weeks should be informed that the possible effects of the drug on the foetus are not known. (Ensure that pregnant women are referred for appropriate antenatal care.)

- This preventive treatment consists of three ARV drug regimens, to be taken daily for 28 days.
- All antiretroviral agents have been associated with side effects, therefore the toxicity profile of ARV agents including the frequency, severity, duration, and reversibility of the side effects should be considered before initiating PEP and during the follow up period. Some side effects are relatively minor and appropriate counselling will help people take the full dose for PEP.

- All PEP antiretroviral agents might have potentially serious drug interaction when used with certain drugs concomitantly. Careful evaluation of all medications used by the survivor/Victim is required before PEP is prescribed and the individual closely monitored for toxicity.

PEP steps in managing a survivor/Victim of sexual violence at facilities other than health facilities (hot spots)

PEP provision to the survivor/Victim of sexual violence takes priority over any other intervention unless the survivor/Victim has severe injuries such as vaginal or anal tears and is bleeding profusely. In such case attendance to the injuries takes priority. In such cases, the provider should refer the survivor/Victim immediately to a hospital but having given the start dose of PEP because it is more effective when taken within 2-72 hours. It is important to remember that PEP in sexual exposure is a reserve for rape and defilement only and not for casual sex exposures.

The following are the steps to be followed when managing exposures through sexual assault:

1. Take a quick history to get the survivor/Victim's particulars and circumstances under which s/he was exposed.

2. Conduct a pregnancy test if survivor/Victim is in reproductive age. If negative, give an emergency contraceptive pill after counselling her. If positive, refer the survivor/Victim to the nearest hospital for proper assessment and provision of appropriate ARVs.
3. Conduct pre-test counselling to allay anxiety, enable the survivor/Victim to accept HIV test and ARVs for PEP
4. Take off blood for HIV Test
5. Conduct HIV test for survivor/Victim /victim

6. Give ARVs for PEP within 2-72 hours without waiting for HIV test results if these cannot be accessed immediately. ARVs must be taken for 28 days.
7. Give a Post Test Counselling when results are received
8. If the HIV test results for the survivor/Victim /victim are positive immediately discontinue the PEP and refer for assessment for chronic care management.
9. Refer survivor/Victim to nearest hospital for assessment of injuries if any, management and follow up.
10. Give return dates for assessment at 4 wks, 3 months and 6 months. During the return dates, do HIV Test to assess the sero-status. Some survivor/Victim s may seroconvert even after receiving ARVs for PEP.
11. Document the incident on the PEP documentation form

PEP steps in management of survivor/Victim s of sexual assault at Hospital

1. Take a brief history if the hospital is the first point of contact.
2. Counsel the survivor/Victim to allay anxiety, about adherence to ARVs and practicing safe sex
3. Take off blood for HIV Testing
4. Provide ARVs for PEP within 2-72 hours if not already provided at first health facility.
5. Take a detailed history without rushing and in a sensitive manner and not being judgmental. During the history taking, inquire after orifices involved in the assault since many women will not disclose forced oral or anal penetration without direct questioning
6. Document the orifices used in the assault, the timing of the assault, prior and subsequent consenting sexual intercourse, use of condoms by the assailant, and whether or not ejaculation had occurred.
7. Inquire after the past medical history, gynecological, menstrual and contraceptive history. It is important to know the medications the survivor/Victim may be taking because of drug interactions between ARVs and other drugs. It is also important to know if the survivor/Victim is on ARVs. Menstrual history is important in case emergency contraception may be required.
8. Inform the survivor/Victim that the information given will be confidential but that some information may be disclosed to the police in which case a signed consent is essential and that court may order disclosure of all information divulged during the consultation.
9. Confirm that the consent for was signed
10 Fill in the PEP documentation form (print and disseminate)
11. Examine the survivor/Victim but injuries requiring immediate attention will take precedence over any other examination. During the examination, findings should be documented bearing in mind that occasionally the Doctor may be asked to produce a medical report at a later date.

12. If the assault is recent, accurately document injuries found on genital inspection (diagrams may be useful) and Petechial hemorrhages on the palate should be sought where there is a history of forced oral penetration.
13 Perform anal examination including proctoscopy if there is a recent history of forced anal penetration, noting any trauma
15. Investigate for STDs and any other condition

HCT in PEP service provision

HCT is the entry point to PEP service provision. It is important that the survivor/Victim is given both Pre-Test and Post-Test Counselling. The following points should be covered when counselling the survivor/Victim on PEP:

- The level of risk of HIV transmission during rape is not exactly known, but the risk exists, particularly in settings where HIV prevalence is high.
- It is recommended that the survivor/Victim's HIV status is known prior to starting ARVs, so that the best treatment option can be made for her/him.
- Scientific evidence shows that when you take the prophylaxis you may not develop HIV/AIDS.
- Explain the common side-effects of the drugs, such as feelings of tiredness, nausea and flu-like symptoms. The survivor/Victim should be reassured that these side-effects are temporary and do not cause long-term harm. Most side-effects can be relieved with ordinary analgesics, such as Paracetamol, spreading out the doses and taking medicines after meals. Survivor/Victim should be given information on symptoms of serious and persistent side effects, so that they can recognize them and return for review.
- Provide information on avoiding further transmission of HIV during the period of PEP surveillance and ARV administration.
- Provide the survivor/Victim with a patient information leaflet, adapted and translated in the local language.

For the HC3s which are not accredited to provide ARVs they should have one-week Starter Park.

Drugs used in PEP

Sexual exposures are considered to belong to high risk category. As such, a three drug combination regimen is recommended for PEP. The drug combination depends on the ARV regimen available at the time and the attendant guidelines for first line treatment. The recommended regimens comprise of 2 NRTIs plus 1 PI or 2 NRTIs plus 1 NNRTI.

Survivor/Victim s should be given a one-week's supply of ARVs for PEP at the first visit and requested to come back after one week for follow up. The remainder of the drugs (another 3-weeks' supply) should be given at the one-week follow-up visit. For

survivor/Victim s who cannot return for a one-week assessment for logistic or economic reasons, a full supply of ARVs should be given at the first visit.

Recommendation for the selection of Drugs for HIV PEP

- AZT (Zidovudine) 300mg BD + 3TC (Lamivudine)150mg BD + LPV/r (Lopinavir/) 400/100mg BD is the preferred combination
- AZT (Zidovudine) 300mg BD + 3TC (Lamivudine) 150mg BD + EFZ (Effavirenz) 600mg OD
- AZT (Zidovudine) 300mg BD + 3TC (Lamivudine)150mg BD + NFV (Nelfinavir) 1250mg twice a day
- d4T (Stavudine)40mg twice a day + 3TC (Lamivudine) 150 mg twice a day + EFZ (Effirvirenz) or NFV (Nefinavir) 1250mg twice a day or LPV/RTV 400/100mg twice a day
- d4T (Stavudine) 40 mg twice a day + ddI (Didanosine) 400mg once a day + EFZ (Effirvirenz) or NFV (Nefinavir) 1250mg twice a day or LPV/RTV 400/100mg twice a day

Adolescents > 40 kg and adults, including pregnant and lactating women

Treatment	Prescribe	28 days supply
Combined tablet containing zidovudine (300 mg) and lamivudine (150 mg) **or** zidovudine (ZDV/AZT) 300 mg tablet **plus** lamivudine (3TC) 150 mg tablet	1 tablet twice a day **or** 1 tablet twice a day **plus** 1 tablet twice a day	60 tablets **or** 60 tablets **plus** 60 tablets

Children*

Weight or age	Treatment	Prescribe	28 days supply
< 2 years or 5 – 9 kg	zidovudine (ZDV/AZT) syrup** 10 mg/ml **plus** lamivudine (3TC) syrup** 10 mg/ml	7.5 ml twice a day **plus** 2.5 ml twice a day	= 420 ml (i.e.5 bottles of 100 ml or 3 bottles of 200 ml) **plus** = 140 ml (i.e. 2 bottles of 100 ml or 1bottle of 200 ml)
10 - 19 kg	zidovudine (ZDV/AZT) 100 mg capsule **plus** lamivudine (3TC) 150 mg tablet	1 capsule three times a day **plus** 1/2 tablet twice a day	90 capsules **plus** 30 tablets
20 - 39 kg	zidovudine (ZVD/AZT) 100 mg capsule **plus** lamivudine (3TC) 150 mg tablet	2 capsules twice a day **plus** 1 tablet twice a day	120 capsules **plus** 60 tablets

* From: *Medical care for rape survivor. MSF draft guideline, December 2002.*

*** A bottle of syrup should be discarded 15 days after being opened.*

ARVs not recommended for use in PEP

The following drugs are NOT recommended for use in PEP primarily because of the higher risk of life threatening side effects:

- Abacavir
- Combination of DDI and D4T
- Nevirapine
- Delavirdine
- Zalcitabine

Efavirenz is contraindicated in pregnancy due to its teratogenic effects.

Drugs and their Side Effects

Antiretroviral Drug	Primary Side Effects
Nucleoside Reverse Transcriptase Inhibitors (NRTIs)	
1. Zidovudine	Anaemia, neutropenia, headache, insomnia, nail discoloration, weakness and muscle pain
Non Nucleoside Reverse Transcriptase Inhibitors (NNRTIS)	
2. Lamivudine	Abdominal pain, nausea, diarrhoea, rash, and pancreatitis
3. Efavirenz	Rash (including cases of Steven-Johnson Syndrome), insomnia, somnolence, dizziness, trouble in concentration and nightmares
Protease Inhibitors (pies)	
4. Lopinavir	Diarrhoea, fatigue, headache, nausea, increased cholesterol and triglycerides
5. Nelfinavir	Diarrhoea, nausea, abdominal pain, weakness and rash
6. Indinavir	Nausea, vomiting, diarrhoea, loss of appetite, stomach pain, headache, rash, kidney stones with blood in the urine, muscle pains, general malaise, fever, jaundice, raised blood sugar and haemolytic anaemia.

Management of Side Effects

- Adverse symptoms e.g. nausea and diarrhoea are common and are manageable with no need to change the PEP regimen with antimotility or antiemetic agents.
- In some situations, modifying the dose interval i.e. taking drugs after meals or administering a lower dose of drug more frequently throughout the day might help alleviate the symptoms.
- Survivor/Victim on indinavir should take plenty of water; at least 2 litres per day
- In case of severe anaemia, the survivor/Victim should be transfused immediately
- The survivor/Victim should be referred to a doctor experienced in HIV treatment.

POST EXPOSURE PROPHYLAXIS DOCUMENTATION FORM

Name of Health Facility……..Level of facility……

Ownership (NGO/Private for Profit/Public) ……..……

Name of client……Age…….. Sex……..……

Occupation/professional cadre of exposed person..……

Place of work……..……

Place where injury took place ……

Date of exposure (dd/mm/yyyy) ……Time of exposure ……..……..

Date reported ……..…. Time reported ……..……

Client accepts/refuses PEP (YES/NO) ……

Reasons for refusal of HIV Test……..

……

..

Date PEP started ……..…… Time PEP started ……..……..

Drug combination given (indicate doses) ……....

……..

Name of attending clinician……

Likelihood of infection in the exposure source is (circle): High Medium Low

Give reasons ……

……..

Tick (√) as appropriate in the table below:

Particulars about exposure	**Yes**	**No**
Type of exposure		
Needle stick injury		
Contaminated broken ampoule		
Sharp equipment		
Splash with blood/liquor		
Exposure to semen, CSF, pericardial effusion etc		
Others (specify)		

Area of contact		
Penetrating injury		
Contact with intact skin		
Contact with broken skin		
Contact with eyes/mouth/nose		
Rape/defilement		
Human bite		
Circumstances surrounding exposure		
Was recapping		
Patient suddenly moved		
Found needle/sharp on trolley/bed		
Was conducting delivery/operation		
Was retrieving something from waste bin		
Type of needle/device		
Solid/narrow bore/wide bore needle/device		
Type of body fluid involved		
Blood/liquor/semen/CSF/synovial/pericardial/pleural fluid		
Others (specify)		
Amount/nature of fluid involved		
Fluid visible on needle/device		
Fresh blood/fluid on needle/device		
Dried blood/fluid on needle/device		
Site of device/needle		
Artery/vein		
Muscle/skin		
Skin exposures		
Skin intact/skin broken		
Type of percutaneous injury		
Deep puncture with bleeding		
Superficial scratch		
HIV Sero-status (laboratory results)		
Client HIV positive/HIV negative		
Source HIV positive/HIV negative		
For females: pregnancy test results		
Risk of exposure		
No risk/low risk/high risk		
PEP Administration		
Exposed person/next of kin counselled		
Exposed person/next of kin accept PEP		

Drugs administered for PEP		
Review of client		
HIV Status at 4 weeks/adverse reaction to PEP		
HIV Status at 3 months		
HIV Status at 6 months		
Psycho social support and counselling		

Annex 11: Key elements of comprehensive emergency care for survivors/victims of sexual violence

Key elements of a comprehensive package of emergency services for survivor/Victim s of sexual violence include:
Informing women about the possibility of unwanted pregnancy and STIs/HIV following sexual assault.
Counselling women about EC, STI prophylaxis and abortion.
Informing women about their legal rights to services, including EC and post abortion care (if available).
Provision of emergency contraception or referrals to sites that provide EC.
Safe abortion or referrals to sites that provide these services (if available)
Post-abortion care or referrals to sites that provide these services.
STI prophylaxis and treatment or referrals to sites that provide these services.
Testing and counselling for HIV/AIDS.
Follow-up care to ensure that women's broader sexual and reproductive health care needs are met.
Collection of forensic evidence by a qualified health worker or referrals to sites that provide these services
Carry out planning and preparation as follows:
Ensure that the health facilities offer as many services as possible on-site.
Identify referral sites that offer accessible, affordable and quality care for any services that cannot be offered on-site.
Ensure that the health facility has adequate supplies including EC,PEP and STI prophylaxis drugs.
Disseminate protocols for providing these services and ensure that they are available to all providers.
Ensure the organisation has a written protocol for these services that are based on the following:
The type of emergency contraception available within the organisation
The local situation with regard to laws about and availability of safe, legal abortion services.
Local guidelines for STI prophylaxis and treatment (STIs may be resistant to certain drugs in some areas)
Local guidelines about HIV prophylaxis (not generally recommended in low prevalence areas).
Up-to-date local and international recommendations on best practices.
Lessons learned from the experiences of other health programs in the country or region.

Strategies to ensure that forensic evidence is not destroyed in the process of providing care.
Ways to protect the safety of women living in situations of violence.
Strategies to minimise the number of exams, the number of times survivor/Victim s are asked to repeat their story, and the number of places women need to go for services.
Kindness, compassion and respect for confidentiality and privacy.
Ensure the written protocols address the needs of the following sub-groups:
Women who seek services immediately following sexual assault vs. those who seek services at a later time.
Children, adolescents and adults (each group may require different drug dosages and/or have different legal rights).
Women living in ongoing situations of violence vs. women who experience a single incidence of sexual assault.
Provide sensitisation and training to providers that tries to accomplish the following:
Raise awareness of the need for EC and STI prophylaxis and treatment following sexual assault.
Increase knowledge about emergency services for survivor/Victim s of sexual violence.
Understand women's legal rights.
Improve attitudes towards survivor/Victim s of sexual violence and services such as EC and abortion.
Equip providers to counsel women about EC, safe abortion, STIs, and broader reproductive health concerns.
Ensure that providers have the technical skills to provide key services and that they can apply the written protocols.
Ensure that providers do not let their personal views prevent them from informing women about their rights, offering non-judgmental counselling and letting women make their own decisions about their reproductive health.
Monitor and evaluate the effectiveness and acceptability of the written protocols:
Include survivor/Victim s' perspectives in evaluations.

Annex 12: Laws related to physical violence and harassment

Is there a law (or laws) against "domestic violence" or "family violence"?
According to the law, how is "domestic violence" or family violence defined and classified?
What acts of domestic or family violence constitute a crime? Under what

circumstances does the law apply?
Are there criminal, civil or administrative penalties for violating the laws against domestic violence? If so, what are the penalties?
How often are these penalties applied in practice?
Are there other laws that prohibit physical violence, stalking, harassment, or threats against women by non-family members, for example, by a current or former boyfriend? Under what circumstances do these laws apply?

Annex 13: Laws related to sexual violence

How does the law define and classify the crime of rape? Under what circumstances does the law apply?		
Does the law consider rape to be a crime against the person or against family "honour"?		
Does the legal definition of rape include:	YES	NO
a. Anal penetration?		
b. Oral penetration?		
c. Penetration with an object or fingers?		
If the legal definition of rape does NOT include penetration with an object or fingers, does the law recognise a separate type of crime (for example, "sexual assault") for this offence?		
Is rape defined as a (felony) offence punishable by imprisonment or a lesser offence/infraction (not punishable by imprisonment)? If it can be classified both ways depending on the case, please explain what circumstances determine how it is categorised.		
Does the law define marital rape as a criminal offence? If so, under what circumstances does the law apply?		
Does the law recognise any non-penetrative types of sexual aggression against an adult woman as a crime? If so, how are these acts classified and under what circumstances does the law apply?		
What types of evidence is generally required to prove rape or sexual assault against an adult woman?		
What are the penalties for rape and sexual assault against an adult woman?		
What actions are classified by the law as criminal sexual acts when the victim is a **minor**? Are there differences in the way that these acts are classified if the victim is a minor versus an adult?		
When an adult has sexual relations with a minor below the age of 18 **with** her/his consent, under what circumstances does the law consider this a crime?		
When sexual aggression is committed against a minor, does the law classify or penalise these acts differently if the victim is a child versus an adolescent?		
According to the law, is there a legally-recognised "minimum age of consent"? for example, is there a specific age under which sexual intercourse with a child is always recognised as rape?		
When an act of sexual aggression is committed against a minor, does the law classify or penalise this act differently if the victim is a boy versus a girl?		
In cases of rape of a minor, can the aggressor evade criminal responsibility for his act by marrying the victim? If so, specify whether this depends on the age of the victim.		

What are the penalties for sexual crimes against a minor and how do they vary depending on the following aggravating factors?
a. Age of the victim?
b. Relationship between victim-offended?
c. A large age difference between the victim and the perpetrator?
d. Other aggravating factors (specify…….)
Does the law recognise other kinds of sexual crimes such as corruption of minors, commercial sexual exploitation of children, child prostitution, pornography, etc.?

Annex 14: Legal obligations of health workers to report violence

Question	YES (Specify which types of violence)	NO
Are service providers required by law to report cases of any type of physical violence to the authorities?		
a. When the victim is an adult woman?		
b. When the victim is a minor?		
Under what circumstances does the law require health providers to report (**sexual violence** (including abuse, rape, assault, etc) to the authorities?	**YES (Specify which types of violence)**	
a. When the victim is an adult woman?		
b. When the victim is a minor but has already reached the minimum age of consent?		
c. When the victim is below the minimum age of consent?		
d. Other? (Specify……)		
Are there criminal, civil, or administrative sanctions for not reporting a case? If so, what are they? Are they ever imposed, and how often?		
Has your institution developed a policy that lays out the circumstances in which staff members would be expected to report cases of violence to the authorities? If so, when and what types of violence?		

Annex 15: Procedures for reporting violence to authorities when required by law

What procedures should health workers follow for reporting each type of violence mentioned below? (Please include details such as: what types of report health care providers need to prepare, e.g. verbal, written, etc.; where health care providers should submit the report; what is the name of the specific legal or administrative authority.)
a. Violence (physical or sexual) within the family against an adult woman/man.
b. Sexual violence (including rape, assault, molestation) against a minor by someone who is not a family member.
c. Physical violence with the family against a minor.
d. Sexual violence by a family member against a minor.
e. Sexual violence (including rape, assault, molestation) against a minor by someone who is not a family member.

COLLECTING AND PRESERVING FORENSIC EVIDENCE

In cases of physical violence, are health workers in your health facility legally allowed to collect or document evidence that could be admissible in court (for example, by writing up a case report or photographing an injury)? Which types of staff and which types of evidence?
In cases of sexual violence, are any health worker in your health facility legally allowed to collect forensic evidence that would be considered legally admissible by the judicial system, or does the law require that only physicians licensed in forensic medicine be allowed to conduct a forensic exam in cases of sexual violence.
Under what circumstances would a health care provider be required to get involved in a legal proceeding about physical or sexual violence experienced by his or her client? (For example, would a provider ever be asked to testify about a client's injuries in a criminal proceeding?)
If a health worker was to get involved in a legal proceeding related to violence against a client, what kind of support would the health facility offer him/her?

ACCESS TO LEGAL ABORTION IN CASES OF RAPE OR INCEST

Does the law allow abortion in cases of rape or incest in Uganda?
If so, what procedures must be followed in order for a woman to obtain a legal abortion? (In other words, what evidence is required to demonstrate that the pregnancy occurred as the result of rape or incest? What are the procedures for making the request? Where does the woman have to go, etc.?
Are the procedures different if the victim of rape or incest is a minor? If so, what are those procedures?

CONFIDENTIALITY OF MEDICAL RECORDS

Question	**Yes**	**No**
Do adolescent girls have a legal right to keep their medical information confidential from their parents, guardians, husbands or other family members? If not, what are the limits to confidentiality?		
Do health workers have a legal obligation to share medical records of adolescents with their parents?		
Can parents sue to get access to these records?		
Do adolescent girls have the legal right to obtain health services and procedures without their parents', guardians', or husbands' knowledge or consent, including:		
a. Family planning		
b. Prevention, testing or treatment of sexually transmitted infections, including HIV/AIDS.		
c. Any services related to induced abortion, including post-abortion care?		

Annex 16: Women's legal rights within the family

With regard to economic support (for example, food allowance)		
Can a man be legally required to provide economic support to any of the following:	YES	NO
a. His wife?		
b. His live-in partner?		
c. His ex-wife?		
d. His ex-live in partner?		
e. His children from the current marriage/union/relationship?		
f. His children outside the current marriage/union/relationship?		
Where should the request for the support be made?		
What should the request include? In other words, what information or evidence is needed to request economic support?		
To paternity:		
a. Is it possible for a woman to bring a paternity suit/ask a court to recognise a man as the father or her child?		
b. If yes, what is the procedure for requesting a paternity investigation?		
c. How is paternity determined and who makes the final ruling (e.g. a judge)?		
d. Is it possible to appeal the ruling?		
Todivorce:		
a. What are the reasons for divorce allowed by law?		
b. What are the rights of women in divorce cases?		
c. How is the separation of property/assets carried out?		
d. If the woman leaves the common residence for any reason, what is the procedure for avoiding being accused of abandoning the home?		
To child custody		
a. Under what circumstances can a mother lose custody of her children (if any)?		
b. Where can women go for assistance with child custody disputes?		

Annex 17: 3rd Edition Reviewers

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