Standard Operating Procedures Manual

Gender-Based Violence (GBV) and Violence against Children (VAC) in Namibia

National Standard Operating Procedures for the Multi-disciplinary team relating to the Management of Gender-Based Violence and Violence against Children in Namibia

UNITED NATIONS
NAMIBIA

Contents

Terms and Acronyms 3
PREFACE 4
FOREWORD 5
GLOSSARY OF TERMS 6-9
1. Introduction 10
2. Legal and Policy Framework 12
2.1. Offences covered by the Multi-Disciplinary Team 12
a. Combating of Domestic Violence Act No. 4 of 2003 12
b. Combating of Rape Act No. 8 of 2000 12
c. Child Care and Protection Act No. 3 of 2015 13
d. Immoral Practices Amendment Act No. 7 of 2000 13
e. Common Law 13
f. Criminal Procedure Amendment Act No. 24 of 2003 13
g. Prevention of Organised Crimes Act No. 29 of 2004 (S15) 13
h. Trafficking in Persons (Act No. 1 of 2018) Section 3 (1) 13
i. Married Persons Equality Act (No. 1 of 1996) 13
2.2. Offences covered in these SOPs 14
3. Guiding Principles when Assisting Victims/Survivors of Violence 15-19
4. Standard Operating Procedures for Violence-Related Offences 20
4.1 Roles of the Multi-disciplinary Team 20
a. Intake 20
b. Risk assessment 22
c. Interviewing perpetrators of gender-based violence 24
d. Medical assessment 26
e. Forensic interview (for rape cases) 29
f. Statement taking 32
g. Warnings in domestic violence cases 36
h. Applying for a protection order 36
i. Collecting physical evidence 39
j. Counselling and therapeutic care 41
k. Social investigations 43
l. Care plan 44
m. Preparation for court 45
n. Support persons for vulnerable witness 46
o. Court Reports 47
p. Follow-up and debriefing after a court appearance 48
q. Case review 49
r. Follow-up medical care 52
s. Case closure 52
REFERENCES 54
ANNEXURES 55
Annexure 1: SOPS Flow chart 55
Annexure 2: Sexually Transmitted Infections 56
Annexure 3: CCPA Classification of Risk Levels in Child Maltreatment 59
Annexure 4: Evidence of Psychological Effects of Domestic Violence 62
Annexure 5: Definition of Domestic Violence 63
Annexure 6: Definition of Domestic Relationship 65
Annexure 7: Risk Assessment Forms 66-86
Notes 87

Terms and Acronyms

- Child Care and Protection Act No. 3 of 2015 (CCPA)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- Combating of Immoral Practices Act (CIPA)
- Gender-Based Violence (GBV)
- Gender-Based Violence Multi-Disciplinary Team (GBVMT)
- Gender-Based Violence Protection Unit (GBVPU)
- Human Immunodeficiency Virus (HIV)
- Multi-Disciplinary Team (MDT)
- Ministry of Health and Social Services (MOHSS)
- National Forensic Science Institute (of Namibia) (NFSI)
- Post-Exposure Prophylaxis (PEP)
- Post-traumatic Stress Disorder (PTSD)
- Scene Of Crime (SOC)
- Sexually Transmitted Infection (STI)
- Standard Operating Procedure (SOP)
- Violence against Children (VAC)

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PREFACE

The Standard Operating Procedures (SOPs) manual will operate within the limited resources available for a middle-income country like Namibia. The development of these SOPs for intervention and referral is a process that involved several intensive consultations with key stakeholders and service providers who will implement them.

A multi-disciplinary team – comprising medical officers, social welfare workers, the police and prosecutors – is currently providing effective services to adult and child survivors of gender-based violence (GBV). The team has adopted a human-rights based and survivor-centred approach to ensure timely service delivery.

The comprehensive management of individuals seeking services due to sexual and physical assault has to strike a balance between using public health approaches and rights-based approaches.

The SOPs manual describes the clear procedures, roles and responsibilities for each sector, whether these are utilised within a Gender-Based Violence Protection Unit (GBVPU) or any other office.

The goal of these SOPs is to improve the quality and consistency of services for survivors and to standardise the response to Gender-Based Violence (GBV) and Violence against Children (VAC). Similarly, perpetrators of sexual assault or rape may also expose themselves to sexually transmitted infections including HIV. Therefore, if such perpetrators are identified, they may need health services and thereafter be handed over for prosecution and rehabilitation.

This SOPs manual therefore aims to support the multi-disciplinary team in enhancing collaborated efforts to address GBV/VAC.

FOREWORD

I would like to acknowledge all our partners who worked with us to develop the Standard Operating Procedures (SOPs) manual. I express my gratitude to the United Nations Office on Drugs and Crime, Regional Office for Southern Africa (UNODC ROSAF) and the United Nations Children's Fund (UNICEF) in Namibia, for their technical and financial support. I am very thankful for the good collaboration amongst our government offices, ministries and development partners in finalising and approving the document. I am very confident that this SOPs, which is a guide to the day-to-day operations of the Gender-Based Violence (GBV) multi-disciplinary team will pave a solid foundation in terms of quality service delivery and proper referrals for survivors of GBV and violence against children.

Approved by the Inspector General of the Namibian Police.

Liutenant-General SH Ndeitunga, OMS

Glossary of Terms

For the purpose of consistency, this manual has used the following terms throughout. Specific definitions on related items have been provided in the text.

Abandonment: This occurs when a parent or guardian deserts a child without any regard for the child's physical health, safety or welfare and with the intention of wholly abandoning the child.

Age of consent for sex: This refers to the age at which a person is considered to be legally competent to consent to sexual acts. In Namibia, there is no absolute age of consent; the legality of the sexual act rather depends on the age difference between the child and the sexual partner.

Arson: This refers to the malicious burning of another person's dwelling.

Best Interests of the child: This means balancing all the different elements that inform a child's wellbeing and that enable the child to fulfil her/his rights. In deciding what is in a child's best interests, factors that should be taken into account are her/his own wishes, the level of risk to the child, resilience factors that mitigate the risk as well as the child's family circumstances. The Child Care and Protection Act, Act No. 3 of 2015 (Article 3) states that in all matters affecting a child or children in general, the best interests of the child concerned is the paramount consideration.

Care plan: This is a written plan that is updated regularly and agreed to by all relevant parties. It outlines how the victim/survivor is to be cared for, how to meet her/his needs and how to respond to the survivor's difficulties and those of her/his family.

Case management: This entails the process of providing protection and support to individual children and their families who are vulnerable to certain risks, directly or through referral services, and following that process through until specified goals are met. (Refer to the 2014 Child Protection Working Group, Inter-Agency Guidelines for Case Management and Child Protection).

Child: According to the Child Care and Protection Act (CCPA) No. 3 of 2015, this describes a person under the age of 18 years.

Child Care and Protection Act: The Child Care and Protection Act (CCPA) No. 3 of 2015 covers the roles and responsibilities of all professionals – from designated social workers to law enforcement, the courts, and others – who come into contact with children that need protection as well as children who are in conflict with the law.

Child in need of protective services: This refers to a child who is in need of services aimed at providing care, protection, or both care and protection to safeguard her/his safety, security and wellbeing or improving such care, protection or both care and protection (CCPA).

Child labour: This describes the economic exploitation or any kind of work that is likely to be hazardous or interfere with the child's education, or be harmful to the child's health or physical, mental, spiritual, moral or social development.

Child Sexual Abuse and Exploitation: This covers a wide range of offences with a person below the age of 18 years as a victim. These are stipulated in various acts including the Combating of Rape Act (No. 8 of 2000), Combating of Domestic Violence Act (No. 4 of 2003), Combating of Immoral Practices Amendment Act (Act No. 7 of 2000), the Prevention of Organised Crime Act (No. 29 of 2004), Trafficking in Persons Act (Act No. 1 of 2018) and the Child Care and Protection Act (CCPA) (Act No. 3 of 2015).

Consent to medical intervention and surgical operations: This is a process by which a patient is informed about and understands the purpose, benefits and potential risks of a medical or surgical intervention, including clinical trials. The patient then agrees to receive the treatment or undergo the surgical operation. Informed consent generally requires the patient or responsible party to sign a statement confirming that she/he understands the risks and benefits of the procedure or treatment.

A child may consent to a medical intervention in respect of her/himself if the child is 14 years of age or older and a medical officer is satisfied that the child possesses sufficient maturity and has the mental capacity to understand the benefits, risks and implications of the medical intervention; surgical operations include the above as well as cases in which the child is duly assisted by her/his parent/guardian or by the child's caregiver if she/he does not have a parent/guardian.

Client: This refers to individuals who are receiving a service from, or are being cared for by a health care worker, social services or law enforcement officer.

Combating of Domestic Violence Act: This means the Combating of Domestic Violence Act, No. 4 of 2003.

Combating of Immoral Practices Act: This means the Combating of Immoral Practices Act, No. 21 of 1980.

Combating of Rape Act: This means the Combating of Rape Act, No. 8 of 2000.

Complainant: This refers to a person who has a complaint and makes a charge in a court of law.

Consent for HIV testing: Any adolescent from the age of 14 years and upwards can consent to having an HIV test; if the child is under 14 years, and if the person who conducts the pre-test counselling is satisfied that the child is of sufficient maturity and has the mental capacity to understand the benefits, risks and implications of such a test, the child may be tested for HIV.

Corporal Punishment: This describes when a person in authority uses physical force for disciplinary purposes with the intention of causing pain. These actions include slapping, smacking, spanking or beating with the hand or with an implement (e.g. stick or belt). A person may not administer corporal punishment to a child at any residential child care facility, place of care, shelter, early childhood development centre, a school, whether a state or private school, foster care, prison, police cell or any other form of alternative care resulting from a court order (CCPA, Section 228(3).

Crime scene: This describes a location where a crime is suspected to have occurred, or a location where evidence for a suspected crime can be retrieved.

Domestic relationship: This means a domestic relationship as stipulated in Section 3 of the Combating of Domestic Violence Act.

Domestic violence: This means engaging in any acts or courses of conduct stipulated in Section 2 of the Combating of Domestic Violence Act within the context of a domestic relationship as set out in Section 3 of the Combating of Domestic Violence Act.

Emotional abuse: This involves any act including isolation, verbal assault, humiliation, intimidation or any other treatment that may diminish the victim's sense of identity, dignity and self-worth. Individuals who experience emotional abuse tend to have very low self-esteem, show personality changes and may become depressed, anxious or even suicidal.

Gender-based violence (GBV): Gender-based violence encompasses a wide range of harmful actions perpetrated against women, men, girls and boys, where the basis of the action is a person's gender. While GBV is not a legal term as such, it covers a broad range of offences laid down in the Combating of Domestic Violence Act, the Combating of Rape Act, the Combating of Immoral Practices Act (CIPA) and Common Law.

Gender-Based Violence Protection Unit (GBVPU): The Namibian Police Force oversees these specialised centres. Here, medical, law enforcement and social service agencies coordinate the professional evaluation, treatment, protection, investigation, case review and ongoing advocacy for children and adult victims/survivors of sexual and physical violence. Some GBVPUs operate as one-stop centres where all members of the multidisciplinary team are under the same roof; whereas other GBVPUs may not have all services under one roof but have agreements with other service providers to provide integrated services. GBVPUs focus on specific types of GBV, namely, sexual abuse, physical abuse, emotional abuse and neglect. Gender-based violence can occur within or outside an intimate relationship or domestic setup.

Gender-Based Violence Multidisciplinary Team (GBVMT): This is a team or grouping of medical-, law enforcement, social service agencies and other professionals who coordinate and provide specialised investigation, treatment, protection, case review and ongoing advocacy for children and adult victims/survivors of all forms of violence.

Health care worker: These refer to professionals such as nurses, medical officers, midwives and community health workers that provide health services and have undergone specific training in the field of health care delivery.

Incest: This refers to a human sexual activity between family members or close relatives. Incest typically includes sexual activity between people in consanguinity (blood relations) and sometimes between those related by affinity (marriage or stepfamily), adoption, clan or lineage.

Informed consent: This is the voluntary agreement of an individual who understands the issue at hand and has the capacity to give consent, and who exercises free and informed choice.

Informed assent: This is used in situations when a child is too young to give informed consent but is old enough to understand and agree to participate in services. Assent in this case may be verbal.

Integrated case management: This refers to a targeted and coordinated care system that delivers direct services across different technical sectors. Ground rules frame the integration across sectors. This enables individuals who support vulnerable children to know how they can work together in a harmonised and holistic way and be held accountable to the child and to the functioning of the overall system.

Intimate partner: This refers to a husband, wife, boyfriend, girlfriend or lover.

Marriage: This describes a marriage in terms of any Namibian law. In this context, it includes a marriage recognised as such of any tradition, custom or a religion of Namibia and any marriage in terms of the law of any country, other than Namibia where such a marriage is recognised as a marriage under the laws of Namibia.

Multi-Disciplinary Team (MDT): This refers to a team or grouping of medical, law enforcement, social service agencies and other professionals who coordinate and provide specialised investigation, treatment, protection, case review and ongoing advocacy for children and adult victims/survivors of all forms of violence.

Neglect: This refers to a deficit or shortfall in meeting a child's basic needs. This includes the failure to provide adequate health care, supervision, clothing, nutrition and housing as well as meeting a child's physical, emotional, social, educational and safety needs.

Physical abuse: This covers a broad range of offences as stipulated under the Combating of Domestic Violence Act, Common Law and the Prevention of Organised Crime Act.

Place of safety: This means an appropriate place including a foster home or place of safety where a victim/survivor in need of care and protection can be kept temporarily.

Prevention of Organised Crime Act: This means the Prevention of Organised Crime Act (Act No. 29 of 2004).

Psychosocial support: This describes all actions and processes that enable a person and her/his household or community to cope with stress in her/his own environment, to develop resilience and to reach her/his full potential. Psychosocial support enables people and their family members to experience love, feel protected, build meaningful relationships and have a sense of self-worth and belonging.

Rape: Any person who intentionally under coercive circumstances commits or continues to commit a sexual act with another person; or causes another person to commit a sexual act with the perpetrator or with a third person, shall be guilty of the offence of rape. For the definition of coercive circumstances, see Section 2 of the Combating of Rape Act (Appendix 3 of the same Act).

Another definition of rape, according to the Combating of Rape Act, is the "intentional commission of a sexual act under coercive circumstances". To understand this definition, we will have to consider the meaning of "sexual act" and "coercive circumstances" (see Annexure 5).

Sexual Abuse and Exploitation: This covers a wide range of offences stipulated under the Combating of Rape Act, Combating of Domestic Violence Act, Combating of Immoral Practices Act and the Prevention of Organised Crime Act.

Service provider: This describes any person or body of persons that is authorised or approved to provide assistance to victims/survivors of domestic violence; such service providers include the police, community policing forums, faith-based organisations, government institutions as well as non-governmental, voluntary or charitable organisations.

Shelter: This means a facility used to provide basic services, including overnight accommodation, to abused adults and children; children living or working on the streets; or children that voluntarily attend the facility but who are free to leave.

Survivor: This refers to individuals (e.g. women, children and men) who report that they have been physically or sexually abused. The term "survivor" connotes that a conclusion has already been reached – that this person was abused. The term "survivor" is preferable to the term "victim" since the latter implies helplessness and lack of control, which might not adequately describe the life and environment of a person who experiences violence. In this SOPS manual, the combined terms "victim/survivor" or "survivor/witness" have been used as a matter of convenience starting from the point that the concern of possible abuse was first identified. Note that the crime does not have to be proven in court for the term "survivor" to be used.

Trafficking in Persons: This describes the recruitment, transportation, transfer, harbour or receipt of persons by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the 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 (Article 3, Palermo Protocol).

Violence against Children (VAC): This definition of coercive circumstances includes child abuse (emotional, physical, and sexual), child neglect, child labour and exploitation, abandonment as well as any other indecent or immoral act committed against a child.

1. Introduction

This SOP manual provides standard operating procedures to professionals who are part of a Multi-Disciplinary Team (MDT) and are involved in cases of gender-based violence (GBV) as well as violence against both adults and children. Challenges related to the phenomenon of GBV and VAC become insurmountable through fragmented approaches, when different professionals respond in isolation from each other. This manual explores the concept of multi-sectoral response to GBV and VAC. Its aim is to support the inter-institutional and multi-disciplinary intervention and referral actions by establishing a common methodological framework for the relevant professionals, who provide direct interventions to GBV and violence against children (VAC).

It describes clear procedures, roles and responsibilities for each individual involved in the support and assistance of victims/survivors. The SOPs focus on four main response sectors, namely, safety and security, justice, psychosocial assistance and health. They reflect a human-rights based and survivor-centred approach and are designed to be used together with established guidelines and mechanisms related to the response to violence in Namibia.

The manual covers rape cases and includes rape of adult persons as well as child rape, other violent offences against adults as well as cases on violent offences against children the vulnerability of children and people with disabilities other than rape.

Note that the SOPs are colour-coded to emphasise the responsibilities of police, designated social workers and health care workers. Thus, different colours are used to easily distinguish the roles of each profession, namely;

GREEN for police, BLUE for medical officers, GREY for judiciary, RED for forensic social workers/investigators and YELLOW for therapeutic social workers.

Purpose of the Manual

The purpose of these SOPs is to improve the quality and consistency of services countrywide for victims/survivors and standardise the response to gender-based violence, sexual violence and violence against adults, children and others who are vulnerable or have disabilities. Moreover, it aims to improve partnership and effective cooperation between government, NGOs and other key stakeholders.

MDTs use three key methods to improve the health and safety of victims/survivors of violence by:

- Providing specialised timely services through the front-line medical, law enforcement and social workers who respond to victims/survivors of violence;
- Creating multi-disciplinary teams including medical, law enforcement and social workers of relevant ministries to ensure effective, integrated case management and coordination (follow through on services); and
- Ensuring the victim/survivor remains the focus of attention and receives services from multiple agencies in one location.

MDTs help to ensure that adult and child survivors of gender-based violence, abuse and neglect receive timely medical and mental health treatment as well as immediate assistance from law enforcement and social welfare officials.

THE MULTI-DISCIPLINARY APPROACH

It is important to emphasise the need for an integrated, multidisciplinary approach that ultimately benefits the victim/survivor. A multi-sectoral response to GBV represents a holistic and coordinated approach aimed at harmonising and correlating programmes and actions developed and implemented by a variety of institutions (but not limited to these) in the areas of psychosocial welfare, law enforcement (police, prosecutors and justice departments) and health.

The disadvantages of an uncoordinated response to GBV are that:

- The victim/survivor is deprived of integrated support and information;
- The victim/survivor may experience ambivalence and confusion;
- There are delays in providing concrete intervention and/or support;
- Victims/survivors make multiple and repeated visits to service providers, which could result in following an unclear inter-institutional itinerary;
- Various terms and definitions are used;
- Different rules of recording, counting, transmission and aggregation of data are used; and
- There is a lack of accountability by service providers.

Hence, a multi-sectoral response leads to an increased level of safety and support for victims/ survivors through an effective, immediate and consistent services network.

2. Legal and Policy Framework

In Namibia, various Acts of Parliament have made provision for many statutory offences. This section deals with statutory law that governs gender-based violence and violence against children in Namibia. In this section, different offences created by statute law will be identified as well as both common law and statutory crimes that this SOPs manual covers.

Victims/survivors of gender-based violence should be made aware of their rights and the responsibilities of service providers and governmental institutions

2.1. Offences covered by the Multi-Disciplinary Team

The following section aims to give an overview of offences that fall under the mandate of GBVPUs, which are outlined in different Acts of Parliament as well as in common law.

a. Combating of Domestic Violence Act (No. 4 of 2003)

This Act covers offences committed within a domestic setting. It defines domestic violence and a domestic relationship.

In terms of Schedule 1 of the said Act, the following offences can be read with Section 21 of the Domestic Violence Act if committed in a domestic setting:

- Common assault
- Assault with intent to do grievous bodily harm
- *Crimen injuria*
- Kidnapping
- Malicious damage to property (this is for property that a complainant owns or jointly owns with the accused or with one in which the complainant has a substantial interest)
- Murder
- Arson
- Indecent assault
- Robbery where violence or threat of violence is used against the complainant
- An offence under Section 38 of the Arms and Ammunition Act No. 7 of 1996
- Trespassing – Section 1 Trespass Ordinance 3 of 1962
- Any conspiracy, incitement or attempt to commit any offence referred to in the Schedule.

b. Combating of Rape Act (No. 8 of 2000)

In its preamble, this Act provides among others, for the combating of rape, to make provision for the rights of a complainant of rape in bail proceedings, to further regulate the granting of bail to persons charged with rape and to impose certain duties on public prosecutors and police officials relating to sexual offences and bail applications.

Section 2 of the Combating of Rape Act makes it an offence to engage in a sexual act with another person under coercive circumstances.

The Act defines a sexual act as an insertion of the penis or any other object or body part into the vagina or anus or mouth of another person. A sexual act can also be constituted by any form of cunnilingus act or genital stimulation.

Coercive circumstances according to the Act include:

(a) The use of force to the complainant or another person;
(b) Threats that violence will be applied to the complainant or another person;
(c) Circumstances where the complainant is unlawfully detained;
(d) Circumstances where the complainant is affected by –
  (i) Physical disability or helplessness, mental incapacity or other inability (whether permanent or temporary); or
  (ii) Intoxicating liquor or any drug or other substance which mentally incapacitates the complainant; or
  (iii) Sleep

To such an extent that the complainant is rendered incapable of understanding the nature of the sexual act or is deprived of the opportunity to communicate unwillingness to submit to, or to commit the sexual act;

c. Child Care and Protection Act (No. 3 of 2015)

Child Labour and Exploitation

Section 234 determines that child labour and exploitation of children is an offence punishable by N$ 20 000 or five years' imprisonment.

Child Abuse, Neglect, Abandonment and Maintenance

Section 249 provides for offences relating to abuse, neglect, abandonment or maintenance.

Section 254 reads:

(1) Subject to the provisions of Section 227(1), a parent, guardian or other person who has parental responsibilities and rights in respect of a child, caregiver or person who has no parental responsibilities and rights in respect of a child but who voluntarily cares for the child, either indefinitely or temporarily, commits an offence if that parent or care-giver or other person –
   (a) Abuses or deliberately neglects the child; or
   (b) abandons the child and is liable on conviction to a fine not exceeding N$50 000 or to imprisonment for a period not exceeding ten years, or to both such fine and such imprisonment;

(2) A person who is legally liable to maintain a child commits an offence if that person, while able to do so, fails to provide the child with adequate food, clothing, lodging and medical assistance and is liable on conviction to a fine not exceeding N$50 000 or to imprisonment for a period not exceeding 10 years, or to both such fine and such imprisonment.

d. Immoral Practices Amendment Act (Act No. 7 of 2000)

Section 14 of this Act makes it an offence for any person who commits or attempts to commit a sexual act with a child under the age of sixteen years, or commits or attempts to commit an indecent or immoral act with such a child, or solicits or entices such a child to the commission of a sexual act or an indecent or immoral act, and who is more than three years older than such a child; and is not married to such a child, whether under the general law or customary law.

e. Common Law

The following offences are covered under common law:

- Attempted murder (domestic relationship)
- Assault by threat

f. Criminal Procedure Amendment Act (No. 24 of 2003)

This provides for special arrangements for vulnerable witnesses and makes provision for the manner of cross-examination of witnesses under a certain age, and allows for the admission of certain medical records as evidence. In particular, Section 158A (1) states that a court before whom a vulnerable witness gives evidence in criminal proceedings, may, on the application of any party to such proceedings or the witness concerned, or on its own motion, make an order that special arrangements be made for the giving of the evidence of that witness.

g. Prevention of Organised Crimes Act (No. 29 of 2004) (Section 15)

- Trafficking of persons in Namibia or across the border

h. Combating of Trafficking in Persons (Act No. 1 of 2018) (Section 3(1)) (Regulations to be finalised)

- Intentional recruiting, transporting, delivering, transferring, harbouring, selling, exchanging, leasing or receiving a person by means of threat, use of force or other forms of coercion;
- Abduction;
- Fraud;
- Kidnapping, abuse of power or abuse of position of vulnerability; and
- Giving or receiving of payments or benefits to obtain the consent of a person who has control over another person.

i. Married Persons Equality Act (No. 1 of 1996)

The Married Persons Equality Act No. 1 of 1996 abolished marital power with regards to the administration of a joint estate and brought equality between men and woman married in

community of property. It should, however, be noted that these provisions are not applicable to customary law marriages. Furthermore, the common-law position of the husband as the head of the family was abolished.

2.2. Offences covered in these SOPs

Of all the abovementioned offences, note that this manual only covers the following violence-related offences:

- Rape
- Domestic violence offences (inclusive of all gender-based violence offences) [assault, attempted murder, attempted rape, indecent assault and *crimen injuria*]
- Child abuse and neglect
- Arson (domestic relationship)

For cases involving human trafficking, please refer to the SOPs provided in the National Referral Mechanism as well as the SOPs for the Identification, Protection, Referral and Safe Return of Victims of Trafficking in Namibia.

3. Guiding Principles when assisting Victims/survivors of Violence

Based on relevant human rights principles, international human rights instruments as well as relevant Namibian legislation, the following key principles should guide all assistance and protection measures that different role players involved at the GBVPU and in the entire supporting process take.

Following these principles helps to ensure the quality of services and to maintain the dignity and safety of victims/survivors.

Respect for and Protection of Human Rights

Human rights underpin all aspects of humanitarian work. All role players involved need to respect the basic human rights of every assisted victim/survivor of gender-based violence as expressed in the major global, regional and national human rights instruments.

These include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC) and other international instruments and standards. Furthermore, relevant African human rights instruments such as the African Charter on Human and People's Rights and the African Charter on the Rights of the Child, need to be considered as well as national laws and regulations.

Victims/survivors of gender-based violence should be made aware of their rights and the responsibilities of service providers and governmental institutions. Since gender-based violence itself already constitutes a serious violation of several human rights, all efforts to assist and protect victims/survivors should aim to restore their rights and prevent further human rights violations during the supporting process.

Best Interests of the Child

According to the CCPA in all cases concerning a child, the best interests of the child should be the paramount consideration. Where relevant, this would include the child's age, maturity, sex, background, physical and emotional security, views or opinions the child expresses, the child's right to parental care, the nature of the personal relationship between the child and other significant persons in her/his life, the attitude of each parent towards the child, their parental responsibilities and their capacity to provide for the child's needs and the desirability to keep siblings together.

It is thus necessary to apply all guiding principles listed in this manual to children, including their right to participate in decisions that will affect them. A child should be listened to and believed in, and her/his concerns should be taken seriously. If a decision is taken on behalf of the child, the best interests of the child shall be the overriding principle and the appropriate procedures should be followed. It is important to note that cases involving children are complex and there are no simple answers to determine the best interests of each child in an individual case.

Do No Harm

No measures should be undertaken that will make a victim/survivor's situation worse in the short or longer term. Documenting, reporting, monitoring or providing a service to a survivor must be avoided if they will have greater risks than benefits. The response to gender-based violence and domestic violence must not re-victimise the victim/survivor.

Non-Discrimination

Everyone has the right to non-judgemental health and support services. Non-discrimination is a key principle in line with Article 10 of the Namibian constitution and all role players must be impartial. Providing services according to this key principle ensure that role players provide the best possible assistance to all victims/survivors without discrimination on the basis of nationality, sex, gender, sexual orientation, age, disability, colour, social class, race, religion, language, political beliefs or any other status.

Informed Consent

Informed consent is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free and informed choice. This means:

- Explaining why you are questioning the child or others and in whose interests they are being asked;
- Explaining what you will do with the information;
- Ensuring that the child or adult understands the process and has had a chance to ask questions;
- Ensuring that the child or adult knows what may happen next;
- Ensuring that the child or adult knows he/she can ask for clarification and support at all times.

Consent is required from the child or children when:

- A social worker wishes to enter a residence to obtain information regarding the safety of a child who may be need protection services; in such circumstances the social worker will be accompanied by the police and will have a warrant or is confident that a warrant will be issued.

Consent is NOT required from the child's parent or guardian when:

- The child is offered, or requests legal representation or assistance for any proceedings at a children's court (Article 58:7);
- In relation to guardianship and therefore consent, if a child has parents who are themselves aged younger than 18 years and are not married, then the parents' own guardian holds guardianship of both parent and child unless a court has directed otherwise.

Key steps in seeking informed consent or informed assent are:

- Case workers should explain why they are talking to the child or adult at every stage; for example, explaining that someone has expressed concern and why. It is important for the social worker to give this information in a non-judgemental way and to make it clear that the social worker is seeking facts and not automatically believing allegations.
- Make sure that all relevant people have a chance to talk about the situation and express their views and opinions. It is good practice to encourage children who are old enough to make a decision on their own to still involve their families in decision-making, and *vice versa*.
- Record any information that is relevant to the consent. If a child or adult has to give informed consent but is not able to – for example, being unconscious or unable to take a decision because of the effects of pain or alcohol – then this should be documented, and the case worker should seek consent at a later time when the adult or child is in a position to do so.
- It is important not to automatically assume that a child or adult with intellectual impairments or any other disability is not competent to take her/his own decisions. If a social worker is uncertain, she/he should seek the advice and support of the child/adult's health worker. Alternatively, the social worker should discuss the situation with someone with disability expertise.

In order for a child or adult to be able to give consent, she/he must be able to:

- Show that she/he understands and can remember key information relevant to the decision or action that requires consent, including the most important potentially negative and positive consequences of the action;
- Show that she/he has used this information to give consent, for example by explaining in her/his own words why she/he has given consent.

Giving consent voluntarily

This type of consent means the person knows that she/he can also say "no" without suffering consequences. In cases where a decision or action is against the child or adult's wishes, the social worker must state that consent was not provided but that the action taken is in the best interests of the child and be able to explain why.

Consent for recordings

This should be sought from children (and/or their families or caregivers) when they have made a statement in the form of:

(a) Playing a video or audiotape in court, involving a statement that the person has made to another person who give evidence in such proceedings;
(b) A written record of a statement that the person has made to another person who gives evidence in the proceedings concerned.

If it is not possible to give evidence in the formats mentioned in paragraph (a) or (b), then oral evidence relating to the making of the statement according to Sec. 216 A (3) of CPA shall be applicable.

Informed assent

This is used when a child is too young to give informed consent, but is old enough to understand and agree to participate in services. Assent in this case may be verbal. In such cases, the social worker should clearly record in the process notes that verbal assent was provided and state how this was given.

It is essential that all role players should explain relevant actions, policies and procedures in a way that the survivor can fully understand them, before seeking consent to any proposal or action.

Everyone has the right to information on what services are available and how to access these services. In addition, people have the right to be informed about the potential risks and consequences of accepting or declining services. Information should always be honest and complete.

If a role player cannot communicate in a language the victim/survivor understands, she/he should make every effort necessary to secure the assistance of an interpreter for oral and written communication. As participation is dependent on reliable communication, interpreters should be made available at all stages of the supporting process.

In the case of a child survivor, parents or guardians should be consulted on all matters and consent to any action taken as long as they themselves have not been involved in the abuse. According to Article 12 of the Convention on the Rights of the Child, a child's views and wishes should be elicited and considered. To enable children to be well-informed in expressing their views and wishes, it is imperative that they receive all relevant information in a child-friendly language. Information must be provided in a manner that is appropriate to each individual child's age, maturity, level of understanding and ability of expression.

All assistance that social workers or other role players provide to survivors should proceed on the basis of the victim/survivor's full and informed consent.

Consent for mental evaluation to receive medical assistance (Mental Health Act, Act No. 18 of 1973)

This refers to obtaining consent to receive medical assistance in the case where a minor or her guardian applies to receive such assistance; or involving an application by the husband or wife of a person who is not a minor; or by a near-relative of such person who is at least eighteen years of age if such person is not married; or if married, if the husband or wife of that person is not available. If the superintendent is satisfied that no guardian, husband, wife or near-relative is available, a medical officer, registered clinical psychologist, registered social worker, registered nurse or a member of any other class of persons designated by the Minister by notice in the Gazette may make such an application.

Mental evaluation for accused persons (Criminal Procedure Act, Sections 77, 78)

When there is an assumption that an accused is mentally incapable to stand trial, the court orders a state psychiatric unit/facility to conduct a mental evaluation.

All assistance that role players provide to victims/survivors should commence on the basis of her/his full and informed consent. It is essential that all relevant role players should explain relevant actions, policies and procedures in a way that the victim/survivor can fully understand them, before seeking consent to any proposal or action.

Self-Determination and Participation

In recognition of the right and need of victims/survivors to make their own informed choices and decisions, staff members of service delivery organisation should encourage them to participate as much as possible in the decision-making process regarding their case. Staff should empower victims/survivors to restore their self-respect and autonomy, and to make informed and safe decisions for themselves and their families. Role-players always need to adopt a non-judgemental approach towards victims/survivors and respect the decisions they make about their support.

Confidentiality and Right to Privacy

Relevant role players need to treat all information and communication regarding a victim/survivor and her/his family with regard to their right to confidentiality and privacy. From their first contact with the victim/survivor until the assistance process is completed, role players need to reassure the victim/survivor that all personal information regarding the person and the case will be kept confidential. Confidential information includes, but is not limited to, information the victim/survivor provides as well as well as information that health workers, designated social workers, police and other service providers provide.

All role players need to ensure that staff members handle all data responsibly. This entails only collecting and sharing information related to the survivor's case and with her/his informed written consent. According to the "need-to-know" principle, role players should only ask relevant questions; moreover, they should only collect and share information that is necessary to handle the case successfully. Remember to always obtain the written consent of the survivor/victim when sharing information about her/his case with other agencies or service providers.

Whenever possible, role players should try to conduct interviews and examinations in private settings. In addition, they need to maintain all written information about survivors in secure, locked files. If any reports or statistics need to be made public, all identifying personal information (name, address, etc.) should be withheld when reporting, compiling and sharing data.

In the case of a child victim/survivor, staff needs to make sure that she/he understands that information will be shared with parents and/or guardians to ensure her/his safety and security, provided a parent or guardian is not the offender.

Safety and security

It is essential to ensure the safety of the victim/survivor and her/his family at all times and place this at the centre of all services provided. It is the role player's responsibility to ensure that the survivor is safe from further violence and to avoid re-traumatisation during the supporting process. Furthermore, all role players need to remain aware about the safety and security of people that are supporting the victim/survivor (e.g. friends or family members).

Strengths-based assessment

A child victim/survivor and her/his family may already know what is working and not working in a particular situation. A social worker may find it useful to focus on the positive aspects when starting a discussion with the child and her/his family members. Initially asking about things that are working very well and whether this constantly happens will make it easier later to find out why these good things do not always go well.

Survivor-Centred Approach

Gender-based violence needs to be recognised as a multi-dimensional social problem since many health, psychological, social and economic issues that affect GBV survivors are closely intertwined. Therefore, service providers need to follow a survivor-centred approach during the entire process to ensure the best individual support for victims/survivors. For example, providing a survivor-focused setting that is comfortable and private ensures an environment that is both physically and psychologically safe for victims/survivors and their non-offending family members. This approach also entails providing adequate supervision of survivors and families and creating an environment that reflects client diversity.

Gender-based violence needs to be recognised as a multi-dimensional social problem

Protection of Survivors of Gender-Based Violence and Children as Vulnerable Witnesses

According to the Criminal Procedures Amendment Act, No. 4 of 2003, victims/survivors of sexual violence and domestic violence as well as child survivors need to be seen as vulnerable witnesses. They are therefore, entitled to special protection and support during the statement taking process and court proceedings. All service providers including designated social workers need to

ensure that they take all necessary and adequate measures to support the survivor/witness during judicial proceedings.

A designated social worker refers clients to social workers in the employment of the state or a private practice whom the Minister responsible for children's issues appoints or designates for a specific purpose or purposes in terms of the Child Care and Protection Act (2015) Section 33 (1) (a) or (b).

Partnership

The multi-sectoral response to GBV implies good cooperation and coordination of involved institutions/organisations.

Gender-sensitive approach

Provided services need to demonstrate an approach that recognises the gender dynamics, impacts and consequences of violence against women. Services should take into account the needs of specific groups of women and girls, including those belonging to marginalised groups. Service providers need to respect the diversity of service users and apply a non-discriminatory approach. This implies that all women survivors have equal and full access to support and receive care at the same level of quality.

4. Standard Operating Procedures for Violence-Related Offences

This section presents the roles of key sectors, which provide services to victims/survivors. Identifying the roles and responsibilities will provide a better understanding of mandates and limits of institutions and service providers and also serve as a base for developing an effective referral system.

In addition, documentation by all service providers to which the case was reported is essential; the documentation, if not the case history, provides at least a comprehensive summary of the most relevant information about an individual GBV incident. Standardised forms, hand notes, charts, photos and paper registries could be used to document a case. Collecting relevant data about each GBV case and gathering them in a database will: a) generate data for monitoring and evaluating GBV cases progress, b) offer a clear view on the disclosed cases in a specific area, and c) help to evaluate the functioning of multi-sectoral response to GBV.

4.1 Roles and Responsibilities of the Multi-Disciplinary Team

Standard operating procedures use colour coding to emphasise the roles and responsibilities of police officers, social workers, medical officers and the judiciary (courts). Thus, green is used to depict police, blue for medical officers, red for social workers, yellow for forensic social workers and investigators and grey for judiciary.

The first step for all violence-related cases is to register at the front desk of the GBVPU/ relevant office.

Core Case Registration at the GBVPU/relevant office

a. Intake

WHAT?

This refers to every person that comes to a GBVPU/relevant office to access services relating to GBV, to see a social worker for counselling or to speak to a police officer regarding an alleged case of gender-based violence, domestic violence or violence against children. This is registered on the database.

After registering a core case, the victim/survivor is referred to the appropriate professionals at the unit/relevant office:

- In cases of rape, the police officer should contact the state medical officer and accompany the victim/survivor to be examined as soon as possible and complete a rape kit. If medical officers are unable to attend to the victim/survivor immediately, she/he should be admitted while waiting to be attended to preserve the evidence.
  The first-line responder should conduct a crisis intervention to secure the survivor's safety. In addition, the victim/survivor should be referred to a social worker within 48 hours for therapeutic counselling, risk assessment and a forensic interview.
- In cases of sexual or domestic violence other than rape, the victim/survivor is issued with a J88 document before being referred to a medical officer for treatment. She/he is then referred or accompanied to the responsible charge station/relevant police office to open a criminal case. If the person decides not to open a criminal case, she/he is referred to a social worker for psychosocial intervention, which includes providing services to the perpetrator.
- Cases of child neglect or child abuse are directly referred to a social worker.
- Timely treatment, support or psychosocial support is provided to victims/survivors.

WHEN?

This happens when a victim/survivor (or guardian) arrives at the GBVPU/relevant office and lays a complaint.

The survivor may come to the unit first, or arrive after having been referred to the GBVPU by any other role player such as a charge office, social worker or teacher.

WHO?

This refers to officials such as a police officer, social worker, medical officer and nurse who work at the relevant facility or at the GBVPU registration desk.

HOW?

During core case registration, the following information needs to be entered into the database:

- Date when the case is reported
- Date when the alleged offence was committed
- Name of the complainant (or the parent's/guardian's name if the complainant is a child)
- Gender
- Age
- Complainant's mobile number
- Type of offence
- Location of offence
- Any forms of disabilities
- Time of offence
- Details of the first respondent (the professional's name and organisation needs to be printed and signed).

b. Risk Assessment

WHAT?

Even though investigating and collecting of evidence are important tasks, the social worker or the police officer (only in the absence of a social worker) should first do an initial risk assessment to assess the victim/survivor's safety and then take appropriate steps to ensure her/his safety in the future. The purpose of this assessment is to determine the level of risk and respond to the survivor's immediate needs. These include placing the victim/survivor in a place of safety, shelter or referring her/him to other service providers.

The social worker should cover the following aspects in the initial assessment:

- Discuss the survivor's safety with her/him;
- Refer the survivor to a support organisation if necessary, such as a shelter or alternative care, in cases of children;
- Assess the survivor's emotional state (this information may later be used for court purposes);
- Inform the victim/survivor that she/he may apply for a protection order in cases of domestic violence and explain how a protection order works in different magisterial districts;
- Explain that issues regarding the maintenance, access and custody of children may need to be mentioned if necessary when applying for a protection order;
- Alert the station commander if necessary about the risk of further violence against the victim/survivor; and
- In cases involving a child, assess the child's safety.

A police officer should focus on the following aspects when conducting a risk assessment:

- Threats of suicide or murder
- Availability of weapons
- Controlling and jealous behaviour; use of drugs and alcohol
- Depression
- Perpetrator's isolation
- Escalation of violence
- Home structure
- End of the relationship
- Choking or strangling
- Pregnancy
- Victim/survivor's own perception of risk

Risk assessment by social workers

Social workers need to perform a comprehensive risk assessment before completing a CM2 form, which should be done no later than 48 hours after a report has been made.

Note that each ministry uses its own strategies, processes and methods when attending to victims/survivors.

Risk assessment by police officers

This focuses on aspects such as:

- Severity of the abuse/neglect;
- Impact of the offender's behaviour on the survivor;
- Survivor's age, physical and mental abilities;
- Frequency of the abuse;
- If the complainant is at high risk, arrange for emergency accommodation;
- If parents are not available, the social worker must assist police; and
- Evaluate the level of supportiveness by parents or guardian.

WHEN?

Intake/reporting

WHO?

Social worker /Police officer

HOW?

Unfortunately, no single assessment instrument can accurately predict the recurrence of gender-based violence. Despite this, the social worker can assist a victim/survivor to identify some of the factors that may indicate an increased risk of further (and more serious) violence.

Possible risk factors are:

- Threats of suicide or murder
- Availability of weapons
- Controlling and jealous behaviour
- Use of drugs and alcohol
- Depression
- Perpetrator's isolation
- Escalation of violence
- Home structure
- End of the relationship
- Choking or strangling
- Pregnancy
- Survivor's own perception of risk

Form CM2 (i.e. information that is included in the database) contains the following:

Part 1: Demographic profile, which needs to be updated on an ongoing basis;

Part 2: Presenting problem for any adult or child case;

Part 3: Rapid risk assessment for any child at risk, to be completed no later than 48 hours after a report has been made;

Part 4: Level of risk and next steps;

Part 5: Case action;

Part 6: Consent for case management; and

Part 7: Respondent information.

c. Interviewing Perpetrators of gender-based violence

WHAT?

Interviewing a perpetrator of GBV or VAC may be a precursor to any work in a case such as doing an assessment or providing holistic services.

Interviews and constructive confrontation are likely to be more successful if they take place closer in time to the victim/survivor's disclosure of the occurrence. This disclosure usually creates a personal crisis for the offender. This is because many offenders believe their partners or children will never disclose due to their belief they have successfully manipulated a survivor to remain silent. Such manipulation may occur in a variety of ways including threats of physical harm, threats to the family, rewards (material or emotional) and religious or cultural adherence.

According to crisis theory, people are more open to acknowledging issues and to new ways of dealing with them during a period of crisis. Sadly, few social workers or other helping professionals interview the accused once a matter of GBV has been reported. This often results in the victim/survivor having to suffer the consequences of reporting or disclosing abuse, which generally incurs the wrath of the perpetrator.

Perpetrators may deny or rationalise their actions.

WHEN?

This takes place as soon as a victim/survivor has reported a case.

WHO?

A social worker should preferably conduct these interviews.

HOW?

The social worker prepares carefully for the interviewing process by:

- Having a clear and detailed account of the GBV incident/s. This may involve making contact with the victim/survivor, her/his family and/or the investigating police officer;
- Accepting the consequences of an acknowledgement or denial by the perpetrator;
- Deciding what can be exchanged for the perpetrator's honesty or disclosure, such as treatment or sentencing alternatives.
- Establishing points of leverage that do not damage the perpetrator, or the relationship she/he has with the social worker or other members of the multi-disciplinary team; and
- Creating a warm and non-judgmental interview environment.

NOTE! It is important to put the perpetrator at ease without losing control of the interview process.

Some interview steps include:

- Getting the perpetrator to relax;
- Obtaining general information about his/her present circumstances – the family constellation, present working situation, social behaviour and activities;
- Exploring his/her emotions related to the incidents and showing empathy;
- Informing the perpetrator of the victim's/survivor's rights and need to be safe;
- Informing the perpetrator of his/her own rights; and
- Providing information on relevant services.

This process may take some time and it is essential for social workers to adopt an empathetic attitude and display interest when questioning and listening to a perpetrator.

During such interviews, many perpetrators may profess their love and commitment to their wife and family. When expressing such sentiments of affection, attachment or the ability to relate to his/her family, the perpetrator may imply that

- He/she did not commit the crime; and/or
- He/she has not harmed the victim/survivor.

At this stage of a confrontation, it is important to talk to the perpetrator about the offence(s) in a matter-of-fact way without being judgemental. The social worker should acknowledge how difficult and courageous it is for the perpetrator to be open about his/her aberrant behaviour.

The social worker may also find it helpful to explore the possible consequences with a perpetrator when acknowledging aberrant behaviour. Most perpetrators anticipate that loved ones and significant others will reject them or that their community may ostracise them.

In cases where a social worker suspects there might be a risk of self-destructive behaviour during this crisis period, it is essential to explore this further by investigating possible immediate support and possibly engaging with the perpetrator about reaching out for help before acting on a self-destructive wish.

Remember! Discuss your plan of action to interview a perpetrator with the multi-disciplinary team at a case conference session.

d. Medical assessment

WHAT?

IMPORTANT! Victims/survivors with severe, life-threatening conditions or injuries should be referred for immediate emergency treatment.

A qualified medical officer should do a medical evaluation on all victims/survivors who are suspected victims of abuse.

All medical care is based on the survivor's consent. This means that no person should be forced to receive any form of examination, treatment or prophylaxis against her/his will.

Any nurse may give a critical care package to a victim/survivor **without** a medical officer having performed a medical examination (see Appendix 1). Note that medical consent is required for HIV testing.

The responsibility of the medical officer is to provide appropriate care, and record the history and other relevant information. This can, in turn, be provided to police officials for use in their investigations and/or to social welfare officers to do follow-up support.

All injuries/evidence must be recorded on the J88 medico-legal report document.

STANDARD: All survivors who are suspected victims of abuse should receive a medical evaluation by a health officer who has received training in the diagnosis and treatment of sexual abuse, physical abuse and emotional abuse.

It is not the health officer's responsibility to determine whether a person has been raped. That is a legal determination. The health care worker's responsibility (i.e. a doctor or forensically trained nurse) is to provide appropriate care, as well as record the history and other relevant information. Police officials can obtain this information to use in their investigations and/or give it to social welfare officers for follow-up support.

Note that a victim/survivor of sexual assault or rape must be attended to immediately upon arrival in a health facility.

Note that the law DOES NOT REQUIRE a victim/survivor to produce a J88 form from the police before she/he can receive assistance. ALWAYS avoid insisting on a police letter, as it not only causes unnecessary delays, but also places a great burden on the victim/survivor.

Children who have been sexually assaulted often act differently than adult victims/survivors. Children may often make a disclosure using some indirect or oblique reference to a person or an incident.

The medical assessment includes the following steps:

- **Full physical examination of the victim/survivor**. This entails performing a full physical examination of the survivor, including forensic examination. (Note that HIV testing requires consent by children older than 14 years). Forensic examination should only be done with the survivor's consent and if it is in the best interests of police investigations.
- **Provision of a medico-legal report (J88).** This includes a summary of the patient's statements, a summary of the medical exam findings and the significance of these findings as well as a summary of any medical or psychological symptoms and their significance.
- **Treatment and prophylaxis.** The aim of the treatment is to prevent unwanted pregnancies and sexually transmitted diseases, including HIV. Laboratory investigations for Sexually Transmitted Infections (STIs) should only be carried out in facilities with available laboratory services. Otherwise, syndromic diagnosis and presumptive treatment should be provided, including emergency contraception, STI prophylaxis, HIV Post-Exposure prophylaxis (PEP) and Hepatitis B vaccination (See Appendix 1). The Medical Officer can also take photographs of injuries of both the survivor and perpetrator with their consent. Gender sensitivity should be applied when photos are taken.
- A health care worker can usually treat a victim/survivor in-situ with injuries such as cuts, bruises and superficial wounds. After the **medical assessment, the police** will submit the evidence from the medical examination to the National Forensic Science Institute (NFSI) **and thereafter refer the survivor** back to a social worker.

WHAT?

Health care workers should be on the lookout for signs such as:

- Vague abdominal pains;
- Poor or altered behaviour;
- Withdrawal,
- Abusive words/language;
- Inappropriate touching;
- Fondling genitals; or
- Difficulty in walking.

If medical care is required, the social worker will also accompany a victim/survivor to the hospital. A child may be hospitalised if necessary. In such cases, the social worker shall assume responsibility over maintenance of the child as the person in charge of a place of safety.

If a police official has issued a formal warning, the social worker will also be responsible for placing the child in a place of safety.

After medically examining or treating a child, the medical officer has a duty to immediately inform the social welfare officer or police if she/he suspects that the child has been physically, psychologically or emotionally injured as a result of physical or sexual abuse.

A report will be given to the person who presented the child for medical care and also given to the case social worker at the GBVPU/ office (Child Care and Protection Act. No. 22 of 2010, Section 33).

WHEN?

As soon as a victim/survivor has been identified during the intake process, she/he must be attended to as soon as possible. In the absence of any medical officer at the GBVPU/relevant office, the police officer or social worker will take the survivor to the nearest health facility to be examined.

WHO?

This entails a medical officer, as most examinations involving children are non-invasive. Where indicated, the child can be referred to a paediatrician or gynaecologist.

HOW?

Take the following steps when obtaining consent for medical treatment from a victim/survivor:

- Explain all aspects of the consultation process;
- Request permission to examine the survivor;
- Ask if she/he wants a guardian and/or social worker to be present;
- Request for permission to submit the medical report to the police if appropriate; and
- Where indicated by forensic expertise in special circumstances, obtain written consent if forensic specimens need to be collected.

It is important that a victim/survivor should get access to prophylaxis even without giving her/his consent for medical examination.

Medical officers must perform a whole-body examination in cases of rape and indicate any related injuries on the J88 document. All information, including follow-up appointments for HIV testing and for trauma counselling, must also be entered in the victim's/survivor's health passport.

The survivor can have access to her medical report from the health facility, but the survivor's health passport should also contain an abstract of the management plan.

When providing prophylaxis, take the following aspects into account:

- **Emergency contraception:** Unless the victim/survivor is currently using contraceptive methods or is currently pregnant; issue post-coital contraception (emergency contraception) as soon as possible – up to 72 hours (three days) after the assault.
- **Sexually Transmitted Infections (STIs) prophylaxis:** Presumptive therapy after sexual assault should be given routinely because it can be difficult to follow up, and also because the victim/survivor may feel more reassured if offered treatment for possible infections. The following infections should be covered: Syphilis, Neisseria gonorrhoea, Chlamydia trachomatis, Trichomonas vaginalis, Bacterial vaginosis, Haemophilus Ducrei, Candida and preventive prophylaxis for HIV.
- **HIV Post-Exposure Prophylaxis (PEP):** Antiretroviral (ARV) therapy is the standard treatment after potential exposure to HIV. The treatment should be initiated as soon as possible, but within 72 hours of exposure. A rapid-HIV test must be conducted after counselling and the victim/survivor should receive the test results immediately. (For HIV Post-Exposure Prophylaxis Eligibility Criteria and Operational Considerations, refer to Annexure 2 of this document).
- **Hepatitis B vaccination**: This vaccination should be given to all victims/survivors of sexual assault who test negative for Hepatitis B antibodies. As Hepatitis B has a long incubation period, it may be given up to three weeks' post-assault. It should be given at intervals of 0 month, one month and six months.
- **Any wounds** should be cleaned and treated. Treatment with the following medication may be indicated: Antibiotics to prevent wounds from becoming infected; an anti-tetanus booster and medication to relieve pain, anxiety or insomnia. (Please refer to Annexure 2 for the Tetanus Toxoid Schedule).

e. Forensic Interview (for rape cases)

WHAT?

The purpose of the forensic interview is to obtain factual information about the incident. This also provides an opportunity to the victim/survivor to talk to a trained professional regarding her/his experiences and concerns about abusive incidents. (The latter refers to gathered information that will support the trauma impact report/and any other report the court requests relating to a specific case).

An important focus of a forensic interview is to use a developmentally and culturally sensitive approach when obtaining a statement or information from a victim/survivor. This information in turn, will support accurate and fair decision making during judicial proceedings. As a fact-finding procedure, it is essential that this interview is both unbiased and neutral in nature. The interviewer may decide to take a short statement from the survivor at the beginning and indicate that a full statement will be taken at a later stage.

In forensic interviews involving child victims/survivors, the use of anatomically detailed dolls can be used to determine important aspects of the abuse.

WHEN?

The forensic interview usually takes place directly after the comprehensive risk assessment or as soon as the victim/survivor is ready to share information about the incident.

WHO?

Social workers and police officers

HOW?

Social workers must conduct forensic interviews in a neutral and legally sound manner, using any appropriate fact-finding method, technique or tool to obtain evidence about the abuse. The interviewing process should also be coordinated to avoid subjecting the victim/survivor to multiple interviews. The interview should take place in a quiet, survivor-friendly room with built-in audio and video capabilities if possible.

For adult survivors

It is important to approach an adult victim/survivor in a compassionate and non-judgemental manner. Other key steps are to:

- Reassure the victim/survivor that she/he is not responsible for the violence or to stop the perpetrator;
- Acknowledge the victim's/survivor's protective strategies; and
- Support and advise the victim/survivor on practical ways to protect herself and her children more effectively.

Interviewing child victims/survivors

Various factors play a role and need to be considered when conducting a forensic interview with a child victim/survivor. These include developmental factors such as the child's age, level of education and maturity, language abilities as well as his/her personality.

The social worker should first speak to a family member alone to obtain more background information. The family member may also possibly divulge details that they might not want the child to hear.

In this conversation, the social worker should gather information about the child's living situation, the caretakers or any other relevant details about mental health issues or previous abuse. In addition, the social worker should obtain background information about the child's abuse history.

No family members should be present during the forensic interview with the child. If a victim/survivor is scared to let go of the parent, she/he should accompany the survivor into the room and play with the child for a few minutes before leaving the room.

If the survivor still refuses to stay on her/his own, the parent can stay provided she/he is not a suspect and has no interest in interfering in the child's statement.

However, the parent has to remain silent and is not allowed to intrude at any stage of the interview.

The social worker can seek guidance on the most effective interview techniques to obtain information involving sexual abuse, for example, by studying detailed assessments involving children or other vulnerable survivors involving suspected sexual abuse.

Techniques that evaluators frequently use, yet yield LOWER confirmatory details about sexual abuse include:

- Crisis intervention
- Assessment (risk assessment) of abused person
- Clinical management for child survivors of rape
- Probation services
- Therapeutic services
- Forensic services
- Monitoring and follow-up
- Play therapy (including anatomically correct dolls)
- Art therapy
- Poem writing
- I-story (depending on age of the child)
- Drawings

Other lower yield techniques are general assessment activities, touch education and hand-drawn anatomical drawings.

Techniques that are used infrequently, yet offer HIGHER yields of confirmatory details about sexual abuse include:

- Anatomical dolls;
- Cognitive interviews; and
- Narrative elaboration.

HOW?

Techniques associated with a likely rating of sexual abuse are the use of anatomical dolls and anatomical drawings.

When interviewing children or other vulnerable victims/survivors, anatomically correct dolls can be used in various ways; namely as an anatomical model, a demonstration aid and to stimulate memory.

There is no predetermined amount of time that must pass during an interview or assessment before the social worker introduces dolls to the child; nor must a predetermined number or type of questions be asked before using the dolls.

Since every child is unique, the interviewer must use her/his judgment to determine when, and if anatomical dolls may be useful.

In some cases, the use of dolls during an interview is not necessary at all. Remember that dolls should only be used when the interviewer needs clarification after a child victim/survivor has made a verbal disclosure.

When initially introducing dolls to a child victim/survivor, it is advisable to present only four dolls; namely an adult male and female, and a child male and female. If the child provides information that suggests multiple parties are involved, the interviewer can introduce additional dolls as the child offers the information.

Note! Only trained professionals should use anatomically correct dolls and other therapeutic techniques.

All anatomically correct dolls should:

- Be sized appropriately so the child can manipulate and hold them easily;
- Have all anatomical openings and appendages;
- Have sexual body parts that are proportionate to the rest of the doll's body size; and
- Have neutral facial expressions.

f. Statement Taking, Case Opening and Preliminary Investigation

WAT?

The A1 Statement is used when a victim/survivor first comes to any GBVPU to report a case or to make a protection order statement. Such survivors should not be sent away; they need to receive assistance in making any statements to minimise the number of referrals, reduce further risk and prevent being re-traumatised.

It is the police officer's duty to take a statement under oath from the survivor/complainant or request her/him to narrate the events that resulted in the incident in chronological order. Police officers must bear the elements of a particular offence in mind when recording a statement from the victim/complainant and ensure that it discloses an offence prescribed by law. In a case involving a minor victim, complainant or vulnerable witness, a social worker must assist the police officer in obtaining statements when required.

During the interviewing process, it is essential to be patient with the survivor/complainant. Remember that a survivor/complainant might be distressed or anxious and therefore find it difficult to tell her/his story in a logical and sequential manner. When the victim/complainant is a minor, keep in mind that younger children in particular, lack the mental capacity to tell a story in a sequential way and might mix up events when giving a statement.

In general, a "disorganised" first statement is not an indication that the person is lying.

When interviewing victims/survivors, it is crucial for police officers to remain objective and control their emotions, whether they involve both disapproval and empathy. Since many cases of GBV and violence against children (VAC) concern private and intimate matters, police officials should focus on collecting only evidence and information that is strictly necessary and directly related to the investigation.

Furthermore, interviewers also need to control their body language as body gestures, facial expression and tone of voice may clearly indicate to a survivor/complainant what the interviewer thinks about the situation.

If the victim/survivor wishes to have a support person present, the interviewer should carefully assess whether such a person is a witness or is otherwise involved in the case. When in doubt, a social worker should accompany the victim/survivor during the interview.

After the police officer has obtained a statement, she/he should ensure that the complainant's case is registered. In the event of applying for a protection order, the survivor/complainant should be referred to the Magistrate's court with a written statement/affidavit where a clerk of the court will assist her/him.

WHEN?

This takes place after the risk assessment has been done.

WHO?

Police officer at the GBVPU/police station

HOW?

Initial investigative considerations regarding the victim/survivor include:

- Obtaining detailed statements from all relevant individuals to include full details of any potential witnesses. This will make it easier to trace them and obtain statements from them. If possible, a video recording of the interview should be conducted;
- Arranging for a forensic medical examination if required. Remember to follow all guidelines as specified from a medical room environment and to take a DNA reference sample from the survivor;
- If relevant, taking possession of the survivor's clothing for forensic examination purposes;
- Ensuring that the victim/survivor receives relevant support through social workers or counselling services;
- Making sure to regularly update the victim/survivor as the investigation progresses; and
- Obtaining a bail statement.

Crime Scene Management (place where the crime occurred)

- Ensure that a forensic examination of the crime scene is carried out as soon as possible while ensuring that the crime scene has been secured to prevent any cross-contamination prior to examination;
- Seize any relevant items of forensic value from the crime scene as exhibits and send them to the National Forensic Science Institute (NFSI) for forensic examination;
- Ensure that complete crime scene photographs are taken;
- Ensure that the Scene-Of-Crime (SOC) team produces a floor sketch plan (with measurements); and
- Use a logbook to record all information about everyone that has been on the crime scene, such as names, date, contact details etc.

Suspect/Accused

- Ensure that the suspect is identified as soon as possible;
- Ensure that a risk assessment is carried out to prevent the suspect/accused putting any other children/victims/survivors at risk of harm;
- Doing a forensic examination of the suspect is critical. i.e. penile swabs, DNA and injuries;
- If relevant, seize clothing of suspect/accused as exhibits and consider doing a forensic examination;
- Establish the movements and actions of the suspect/accused before, during and after the incident (this will also be obtained from the survivor and witness statements);
- Ensure the suspect is arrested at the earliest opportunity while considering what supporting evidence is available; and
- Conduct a suspect interview where appropriate and if he/she agrees to provide a statement as per the POL 17 document (warning statement).

Witnesses

- Identify all witnesses and obtain their statements;
- Seize any relevant exhibits from witnesses ensuring that they are documented in their statement i.e. details of the officer they gave them to, and verifying that they can identify the exhibits etc.

HOW?

Additional considerations

- Ascertain whether there is any CCTV footage such as CCTV cameras and/or CCTV evidence. If so, ensure that such footage is seized as an exhibit as a matter of urgency;
- Telecommunications – this includes determining whether the suspect/accused has a mobile phone, and if the victim/survivor and/or witnesses have a mobile phone. If relevant, seize these mobile phones for examination and use a search warrant to obtain relevant data from the service provider such as billing and cell site locations;
- Media appeal – decide whether it would be beneficial to use the media to issue an appeal for witnesses to come forward. Also enquire whether the media can provide any additional and relevant information; and
- House-to-house search – consider visiting houses near the crime scene or close to any area that is relevant to the investigation in an attempt to identify additional witnesses.

General cleaning protocol in an established GBVPU

Sexual Assault/Survivor Examination Room

- The suite should only be used to perform forensic medical examinations on survivors of sexual assault.
- All attending professionals MUST wear gloves to minimise DNA transfer in the examination room.

In cases of minor victims/survivors or vulnerable witness

In cases involving minor victims/survivors or/vulnerable witnesses, it is strongly advised not to interview them in the presence of a parent or another close relative. These individuals might have a personal interest in interfering with the child's statement and in particular, when it involves violence within the family. Even if the family is not involved in the abuse, a child may not feel comfortable to speak freely, especially about sexual issues, which some cultures still regard as taboo. The parent also does not have to proofread or sign the child's statement. Take the victim/survivor out of hearing range and away from eye contact with the suspect and other members of the public.

It is preferable that a social worker or other appropriate person should support the child victim/survivor in this situation. Ideally, all persons who interview and take statements from children, especially in child protection situations, should have undergone specific training and have specialised skills.

Children may use different words to describe something. Always check to know what the child is talking about, for instance when referring to different parts of the body. Children may remember many events without being sequential. Linking the question to a time/period that children can identify will help them to be more specific.

Use a checklist to ensure the general cleanliness of the examination room

- ✓ Cleaning should be done after every victim/survivor examination
- ✓ Check if bin requires emptying
- ✓ Gloves must be worn for general cleaning
- ✓ Ensure that the following surfaces are cleaned using the disinfectant provided: EXAMINATION BED, DESK, FREESTANDING LIGHT AND VICTIM/SURVIVOR PRIVACY SCREEN
- ✓ Sweep floor
- ✓ Mop floor with a solution containing a mixture of bleach and water
- ✓ Wipe surfaces.

HOW?

Phased approach to interviewing

The phased approach has been shown to be most successful when interviewing a vulnerable witness. It comprises the following seven steps or phases:

Phase 1: Preparation

Preparation is not optional, it is mandatory!

Depending on the specific case, the interviewing professional must decide which approach to take to ensure that the particular interviewing technique "speaks" to the vulnerable witness. Remember, there is no one-fits-all approach.

With regards to the location of the interview, it is important to choose a location which is neutral, yet private and confidential. Avoid any disturbance or disruptions from colleagues or other people; close the door, place phones on silent and if necessary, put a notice on the door that an interview is in progress. If the survivor is a child, the officer should avoid sitting behind a desk during the interview but rather position him/herself at the same level with the child, e.g. sitting on the floor or on a chair next to the child. The child should be allowed to take a toy or anything else that provides comfort.

Phase 2: Rapport Building

Rapport is the positive relationship between interviewer and the victim/survivor that sets the tone for the interview; it helps to increase both the amount and accuracy of the information provided.

This phase involves the introduction of the interviewer and the role in the interviewing process. It is especially important to explain to child survivors what role the police play and establish an understanding of truth and lies. This is also when an interviewer outlines basic rules for the interview. For example, if the child does not know an answer, she/he should not feel obliged to come up with an answer, but rather say she/he does not know.

Phase 3: Information Gathering

A specific interviewing technique has been proven to be the most effective way to obtain a comprehensive and accurate statement. An interviewer using this technique asks questions in the following mandatory order:

1. Free narrative account (relating the story or incidents without disruption)
2. Open-ended questions (unstructured question in which answers are not suggested)
3. Specific, yet not leading questions
4. Close-ended questions (refers to questions that can only be answered through limited responses, such as yes/no).

Starting an interview by asking very specific questions might interfere with the general amount and quality of the evidence given and should be avoided. Therefore, the interviewer should only move away from the free narrative account towards asking close-ended questions when more detailed questions seem appropriate. Even when moving towards more specific questions, the interviewer needs to make sure not to disturb the "flow" of the interview. In case any follow-up questions come to mind during the free narrative, the interviewer should make a note of them and ask them in the next phase, which involves open-ended questions.

Remember to avoid leading questions as children may try to guess which answer will satisfy the interviewer. Moreover, be mindful that children will often give a literal answer or may have different understandings of what a particular word means. When in doubt, find out!

Phase 4: Questioning

If any follow-up questions are revealed during the information gathering phase, they can be asked to get further clarity.

Phase 5: Closure

Interviewers should always end an interview or consultation on a positive note by thanking the victim/survivor for her/his cooperation and for providing the information. Ending the interview positively is even more crucial when the survivor has not provided all the information which indicates she/he has not reached the stage of disclosure.

Remember to inform the victim/survivor about the next steps in the process such as court preparations or court dates, and give her/him the opportunity to ask questions.

g. Warning in Domestic Violence Cases

WHAT?

Section 23(1) of the Combating of Domestic Violence Act, (Act No. 4 of 2003) stipulates that if a police officer reasonably suspects that a domestic violence offence has been committed, he/she may, due to the wishes of the complainant, issue a formal warning. A copy of the formal warning must be served on the alleged respondent; in addition, copies must be provided to the station commander of that specific area and to the Clerk of the Court within the jurisdiction.

Formal warnings should only be issued in minor cases where the complainant does not wish to pursue a criminal case. Also note that they do not apply to repeat offenders.

WHEN?

The warning is issued after an incident has been reported to the police and the complainant (victim) declines to open a criminal case but rather wants a warning to be issued to the respondent (perpetrator).

WHO?

A police officer at the GBVPU or police station issues warnings.

HOW?

When issuing a formal warning, the police officer must fill out Form 11 of the Domestic Violence Act Regulations and clearly indicate the full particulars of the respondent/perpetrator, the name of the victim/survivor/complainant, as well as the type of violence committed.

h. Application of Protection Orders

WHAT?

In cases of domestic violence, the complainant (victim/survivor) can apply for a protection order against the respondent (perpetrator). The aim of a protection order is to prevent possible future violence. It becomes a criminal offence when the respondent violates the order. While victims/survivors cannot violate their own protection order, they can be charged for perjury if they affirm or submit a false statement under oath.

WHEN?

This takes place after the incident has been reported to the police and the complainant does not wish to open a criminal case but rather wants the respondent to receive a warning.

WHO?

Court officials (Clerk of the Court and magistrate)

HOW?

- The application process for a protection order is outlined in Section 6 of the Combating of Domestic Violence Act, Act No. 4 of 2003.
- The person (applicant) requiring a protection order makes an application to Court on the prescribed form.
- Where necessary, the Clerk of Court will assist the applicant to complete the application form.
- The application must be accompanied by an affidavit (sworn statement) by the applicant and contain the following information:
  - the facts on which the application is based;
  - the nature of the order applied for; and
  - The police station, where victims are most likely to report any breach of the protection order.
- Affidavits from persons who have knowledge about the matter may also accompany the application.

Granting Interim Protection Orders

- The Court (i.e. magistrate) should consider granting the order as soon as it receives the application;
- The Court has the discretion to grant or deny an interim (temporary) protection order;
- The Court can immediately grant an interim protection order if there is sufficient evidence to do so, regardless of the fact that the respondent (party against whom the protection order is sought) has not been given notice of the proceedings and an opportunity to be heard;
- If the Court requires further evidence before deciding on whether or not to grant an interim protection order, it may hear oral evidence or evidence of any nature as well as summon any person to appear before it;
- If the circumstances require it, the Court may refer the matter for an enquiry;
- An interim protection order will call upon the respondent to indicate why the interim protection order should not be confirmed (made final) on or before the return date (which is 30 days from the date of the interim protection order);
- After granting an interim protection order, the Court must make sure that the applicant understands that she/he is required to return to Court on the date of the enquiry, at which time the Court must decide on the interim protection order.

Enquiry process

- The procedure or an enquiry is set out in Section 12 of the Act;
- The main purpose of the enquiry is for the Court to determine whether or not the interim protection order should be confirmed (made a final protection order) or discharged (cancelled);
- The parties in an enquiry may call witnesses in support of their cases;
- The Court may summon any person, whose evidence may be considered as being relevant to give evidence in Court;
- Any one of the parties in an enquiry may be represented by a legal practitioner of their own choice;
- Due to the private nature of proceedings in domestic violence matters, the court must ensure that only the following persons are present at the enquiry:
  - ✓ Court officials, the applicant, the complainant (if it is someone other than the applicant) and the respondent;
  - ✓ The parties' lawyers (if they have legal representation) and witnesses;
  - ✓ A maximum of two (2) people for the applicant and respondent respectively, to support the parties; and
  - ✓ Any other person that the Court authorises.

HOW?

Failure to appear

- If the respondent fails to attend an enquiry despite proper notice being given, the Court may:
  - ✓ Proceed to hear and determine the matter in the absence of the respondent; or
  - ✓ Postpone the matter on any good cause shown.
- If the applicant or complainant fails to appear in court on the date of the enquiry, the Court may:
  - ✓ Dismiss the application if it is satisfied that the applicant or complainant no longer wishes to pursue the matter; or
  - ✓ Postpone the matter on any good cause shown.

Outcome

- After conducting the enquiry, the Court may:
  - ✓ confirm or discharge the interim order in its entirety;
  - ✓ confirm specified provisions of the interim order;
  - ✓ cancel or vary specified provisions of the interim protection order;
  - ✓ discharge the interim protection order and substitute another order for the interim order; or
  - ✓ Add provisions that were not contained in the interim order.

Note that a protection order issued at the conclusion of an enquiry is a final protection order

Final Protection orders

A final protection order is valid for three years. The Court will issue a final protection order if the Court is satisfied that domestic violence has taken place, after considering all of the evidence that is placed before it.

The other factors which must be considered are the same as for an interim protection order. The original will be served on the respondent, a certified copy on the applicant and another copy to the Station Commander named by the applicant as the one where she is most likely to report any breach of the protection order.

Different provisions of a protection order can remain in force for different time periods. However, any other provision of a protection order can remain in force for a maximum of three (3) years. The applicant or the respondent can also apply to the Court to change or cancel a protection order at any time.

i. Collecting Physical Evidence

WHAT?

The aim of a police investigation is to achieve a specific outcome, namely, to present evidence in criminal court proceedings. Criminal proceedings seek to obtain a fair conviction and an appropriate sentence where applicable.

Key rules involving evidence is that it:

- Must be **relevant** (this means there must be a link between the evidence and the legal elements that the prosecutor is aiming to prove);
- Must be **admissible** (this means that it must comply with the rules of evidence, for example, hearsay evidence is generally not allowed).

  When considering the link between available evidence and the elements that need to be proved especially in the context of sexual violence, it is helpful to consider three sites of evidence collection:
  - ✓ Crime scene(s) (where violence happened) – for example, a perpetrator's car (used to abduct his/her victim) or his/her house (where the sexual violence took place);
  - ✓ The victim/survivor's body and clothes; and
  - ✓ The suspect's body and clothes.

A rape kit must always be taken in rape cases if it was reported within 72 hours of the incident.

If available, the clothing of both the survivor and the perpetrator should be collected for the purposes of DNA analysis.

The investigating officer must obtain statements from relevant witnesses to corroborate the survivor's statement and strengthen the state's case.

Handling evidence after a medical examination

It is the duty of investigating officers, detectives and/or scene-of-crime officers to collect, package and label all physical evidence and forward it to the National Forensic Science Institute (NFSI) for forensic examination, such as evidence from a crime scene examination and survivor medical examinations.

The NFSI uses the following guidelines when handling evidence:

- The Institute only issues a laboratory reference number and registers the case if a case has been registered, and the CR number and a reference sample of the accused person(s) or suspect(s) are available for reference purposes.
- If a case number has been registered, but no reference sample of the accused person(s) or suspect(s) is available, the NFSI will not register the case in its Register or assign a laboratory reference number to the case.
- In this situation, the case will merely be stored at the NFSI without performing a scientific examination on the exhibits until a reference sample of the accused person(s) or suspect(s) has been submitted.
- Once reference sample(s) of the accused person(s) or suspect(s) have been submitted, the NFSI will register the case and assign a laboratory reference number before it is submitted for scientific examination.
- If neither a case number nor a reference sample of the accused person(s) or suspect(s) is available, the exhibits will be submitted to the NFSI for storage only. The exhibits will only be retrieved from storage upon written request by the submitting authority.

WHEN?

The crime scene must be visited as soon as possible after the incident has been reported.

Note that a rape kit of the victim/survivor MUST be taken within 72 hours of the rape.

WHO?

It is the duty of the investigating officers at the GBVPU/police station to conduct investigations and collect evidence in rape cases.

HOW?

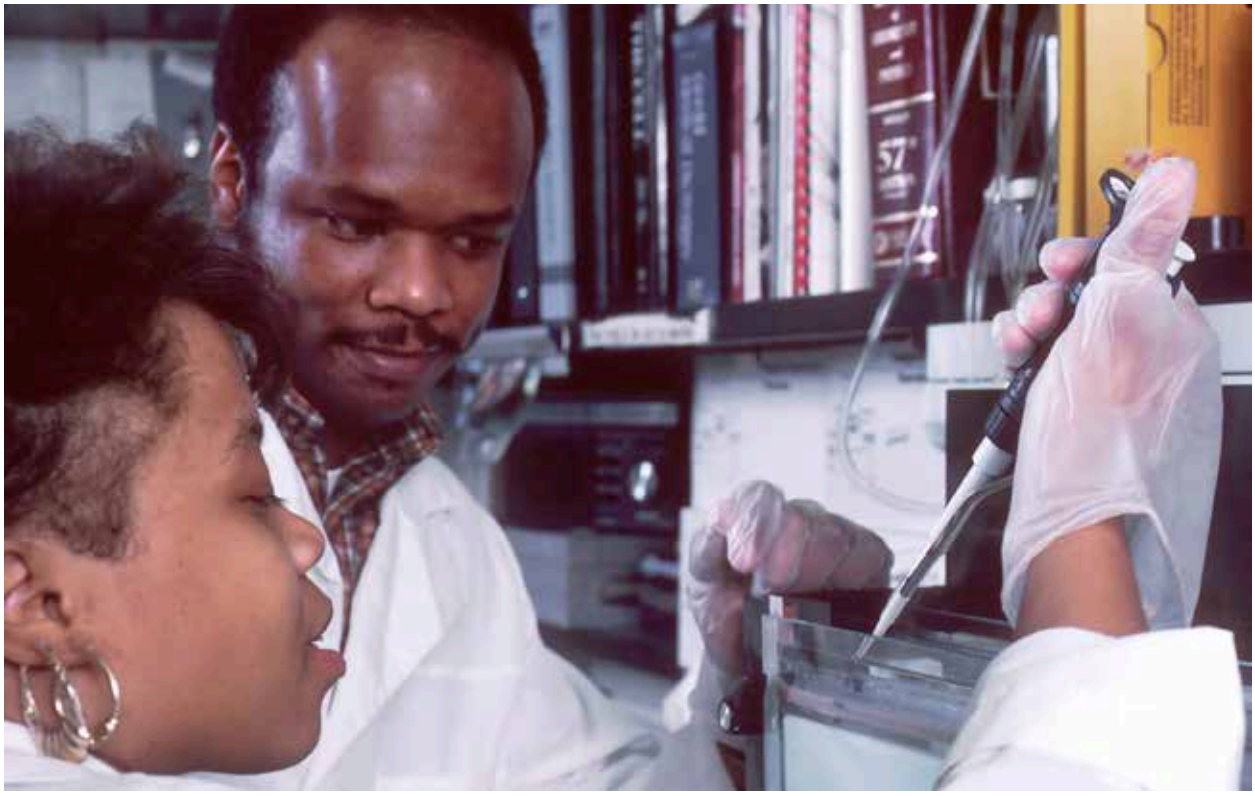
Taking control and securing the crime scene is an important phase in the investigation process. It is vital that potential clues should not be moved or destroyed.

A scene-of-crime officer is tasked with photographing the crime scene, collecting physical evidence as well as compiling a sketch plan and grouping photographs.

The chain of custody involves every person that handles physical evidence, from the beginning of the collection process to the presentation of evidence in Court.

It is therefore important to prevent too many people from handling the exhibits so the chain of custody evidence is not compromised or extended unnecessarily.

The chain of custody plays an active role insofar as it involves the acceptability of physical evidence to the Court. Everyone who has had custody of the physical evidence must give a written statement under oath/affirm. They may also need to testify in Court regarding the condition of the exhibits during their possession.



j. Counselling and Therapeutic Care

WHAT?

Counselling refers to the provision of professional assistance and/or guidance in resolving a personal or psychological problem. Therapeutic care uses a holistic, individualised and time-based approach to address various complex issues. These include the impact of trauma, abuse, neglect, separation from families and significant others as well as other forms of severe adversity.

A therapeutic interview aims to help victims/survivors develop coping mechanisms and use different interventions to support the healing process.

Therapeutic services for victims/survivors include:

- Providing crisis intervention services;
- Doing trauma-specific assessments, including full trauma history;
- Using standardised measures (assessment tools) initially and periodically engaging with the family/caregiver;
- Providing individualised treatment plans that are re-assessed regularly;
- Providing individualised, evidence-informed treatment that is appropriate for victims/survivors and their families;
- Making referrals to other community services as needed; and
- Using clinical supervision.

WHEN?

Therapeutic services should be provided as soon as a survivor's case is reported. The report can be submitted to social workers or other first-line respondents for a risk assessment, forensic interview or for a statement by a police officer.

WHO?

Social workers, mental health nurses and partner NGOs may all provide psychological counselling as long as they have received training in an evidence-based and trauma-focused method and also receive professional support.

HOW?

Case conferencing

This refers to a formal meeting in which relevant stakeholders from different sectors or organisations review, plan or discuss a case. Each case is discussed based on a client's identified needs, responses and required services as outlined in the CM11 document (Case Management Form number 11).

The purpose of a case conference is to review interventions and make formal decisions in the best interests of the victim/survivor. It is documented using Form CM6 and can take place at any point in the case management process. Depending on the merit of each case, this meeting will involve the victim/survivor, family or any other concerned party/ties if needed. The team can adopt the survivor's care plan accordingly.

The case conference is an information-sharing forum that focuses on identifying the strengths and challenges a victim/survivor and family face, and agreeing on a plan of action to support the survivor and enhance her/his strengths. Aside from a case conference, the social worker may continue to hold separate meetings with the survivor and family, which are sometimes called a family group conference.

Such meetings can also help to ensure that the interventions are appropriate and are in the best interests of the survivor.

The therapeutic process consists of different intervention levels, namely, individual, family and group therapy, case conferencing as well as connection to any other service or resources when required.

Steps in therapeutic interviewing process

1. Intake and Engagement – welcome, introductions and rapport building
2. Data Collection and Risk Assessment – gather information to establish strengths and weaknesses in family system
3. Planning and Contracting – joint planning regarding the way forward, desired goals or outcomes from client and social worker, contracting
4. Intervention and Monitoring – action, implementing the plans
5. Final Evaluation and Termination – summarise, evaluate and terminate the process.

Assessment for basic psychosomatic symptoms

During the counselling process, designated social workers screen the victims/survivors for psychosomatic symptoms in order to assess the stress that emotional trauma places on the body.

Psychosomatic symptoms may include but are not limited to: headaches, stomach aches, increased or decreased appetite, constipation and bedwetting or urination on oneself in the case of a child.

Questions about mental health are not only important to identify the services needed; their responses can also be used as admissible evidence as stated in Section 31 of the Combating of Domestic Violence Act of 2003 and Section 8 of the Combating of Rape Act No. 8 of 2000. This means that a social worker can refer a victim/survivor to a psychologist if a full mental health screening is required as evidence.

Mental health services for non-offending family members and/or caregivers are routinely made available on-site or through linkage agreements with other appropriate agencies or providers. These services include screening, assessment and treatment on-site or by referral. It is important to consider the range of mental health issues that could impact a victim's/survivor's recovery or safety.

In particular, pay attention to a caregiver's mental health, substance abuse, domestic violence and other trauma history if relevant.

k. Social Investigation

WHAT?

Social investigation includes conducting an in-depth, comprehensive investigation of the survivor's circumstances, including consultations with various relevant parties. It focuses on the survivor's underlying strengths and challenges. **A social investigation is conducted on all victims/survivors who have been assessed as "medium risk" or "high risk" during intake and risk assessment.**

Form CM3 must be completed in the case of a child victim/survivor who will appear before a Child Welfare Commissioner.

This process refers to:

- All children for whom a warrant was issued under CCPA Article 134:2 and stipulates their removal or the removal of an alleged offender;
- All children who require placement in alternative care, which includes all children who fall under CCPA Article 131:1 and who lack a suitable caregiver;
- Children who fall under CCPA Article 131:2 and for whom a social worker decides after conducting a social investigation that there should be a formal court record of proceedings.

In the case of an adult victim/survivor, the social worker's professional investigation or a forensic report as well as other relevant supporting documents can assist in obtaining an interim protection order or process a placement at a safe house or shelter.

WHEN?

After the risk assessment

WHO?

Social worker

HOW?

The social investigation (Case Management form 3) entails doing a full assessment of a child or adult's situation to identify possible risks and execute an appropriate response. The social worker must explore underlying reasons for risks that a child or adult may face and also consider the survivor's strengths and resilience levels and those of her/his family in order to reduce risk.

This form is also completed in cases where children were temporarily placed in alternative care or where a statutory report needs to be provided to the Court.

A court report (Form CM3a) provides an analytical summary of the social background screening findings, together with key factors and clear recommendations. Gathering information about a survivor's social circumstances is an important source of information for psychosocial support services. It can also be used when necessary to compile reports for the Court.

Information-gathering actions may include:

- Identifying a survivor's psychosocial support needs;
- Identifying resources and stakeholders;
- Developing a care plan and conducting home visits; and
- Collecting any other relevant information.

I. Care Plan

WHAT?

A care plan outlines individual goals for the social worker, victim/survivor and all other role players that are directly relevant to a survivor's problems. It needs to be measurable and realistically achievable within a set time frame.

Other key elements of the care plan are to:

- Address specific changes required to risk of harm to the victim/survivor;
- Promote the survivor's wellbeing; and
- Further develop a survivor's strengths and responses to challenges as documented in Form CM3.

Note that the CM3 form is used for child survivors.

WHEN?

The social worker can develop a survivor's care plan after the risk assessment or social investigations has been completed.

WHO?

Compiling a care plan involves the social worker, the victim/survivor, her/his family and other key role players.

HOW?

It is essential that the victim/survivor and trusted family members where appropriate, contribute to, and agree on proposed goals. Note that developing a care plan is applicable to all victims/survivors who have been assessed and deemed to be at medium or high risk.

By involving all important role players including police officers, prosecutors and community service providers when developing a care plan ensures that they can provide the necessary support and intervention strategies.

Examples of such interventional strategies may include prevention and early intervention (parenting support for a mother or life skills for child) and other specialised services such as education guidance, disability support and HIV counselling.

Thus, the care plan focuses on the victim/survivor's entire protective environment – siblings, parents/guardians/caregivers, extended family, peers and the broader community. In the case of domestic violence, the care plan should also include services to the perpetrator in order to work towards restoring the family unit.

m. Preparation for Court

WHAT?

Social workers should be requested to prepare a victim/survivor for the court process in writing 30 days before she/he is due to testify. Court preparation serves to help survivors understand the legal process and the role they must play within this framework.

Another important aim of court preparation is to empower a victim/witness and enable her/her to testify accurately and effectively, except in cases of bail application. This preparation work is especially necessary for children or other vulnerable survivors.

The social worker should strive to coordinate with other disciplines such as law enforcement, health services and court personnel to ensure an effective and comprehensive court preparation process.

Social workers should also be aware that efforts to prepare survivors in isolation may backfire; this approach carries the risk of undermining the goal of justice by influencing a survivor's testimony, or the goal of protection by inviting charges of coaching.

Inter-agency coordination encourages consistency and structure that are not always present if preparation is done on an *ad hoc* basis.

Structured court preparation programmes usually consist of approximately four to eight sessions with one or two post-trial sessions (see also section on debriefing after appearance in court). Combining a single session with a visit to the courtroom before the trial can provide the most basic information.

In the case of a vulnerable survivor, the social worker can recommend that the responsible prosecutor should request special measures to be put in place to create a more survivor-friendly environment in Court. This recommendation for vulnerable witnesses is contained in the Criminal Procedure Amendment Act, Act No. 24 of 2003, specifically section 158 A (1) CPA 51 of 1977.

WHEN?

Court preparation takes place before a survivor/witness testifies in Court.

WHO?

The social worker will prepare the survivor/witness for Court. (Note that the therapeutic social worker cannot be involved in this programme since the social worker is not allowed to discuss the details of the case with the survivor).

HOW?

The court preparation programme includes:

- Assessing the needs of a survivor/witness regarding her/his court appearance;
- Helping a survivor/witness to understand the court process, outline her/his role in Court and clarifying the roles that other participants play;
- Taking the survivor/witness to visit the court venue beforehand or using a photograph or diagram of the Court if it is difficult to arrange such a visit;
- Teaching the survivor/witness different techniques to reduce stress and manage anxiety;
- Involving a parent or caregiver in the case of a child survivor/witness;
- Engaging with judicial role players to communicate relevant information (including the survivor's wishes);
- Keeping the survivor and her/his family informed and updated on the judicial process;
- Ensuring that practical arrangements such as transport are made;
- Accompanying the survivor/witness to Court on the day she/he testifies; and
- Debriefing the survivor and her/his family after the trial.

n. Support Persons for Vulnerable Witnesses

WHAT?

The Criminal Procedure Amendment Act No. 24, 2003 (section 158A) stipulates that one of the special measures the prosecutor can request is to appoint a support person to assist a vulnerable survivor/witness when testifying in Court.

WHEN?

During a court session involving a vulnerable witness

WHO?

A social worker who is **not** involved in the therapeutic or forensic services can do the court preparation.

HOW?

The role of a court support and preparation officer (CSPO) is to:

- Stand or sit near the witness and provide physical comfort to her/him if necessary; and
- Alert the presiding officer to the fact that the witness is experiencing undue stress or anxiety.

The support person may not:

- Assist the witness in answering any questions; or
- Instruct the witness to give evidence.

o. Court Reports: (Case Management Form 3 and Case Management Form 4)

WHAT?

When necessary, the court or the prosecutor must submit a written request to the social workers to compile a **Trauma Impact Report.** The Trauma Impact Report for special arrangements in Court is based on the Criminal Procedures Amendment Act, No. 158 (a), No. 24 of 2003.

The purpose of this report is to assist the Court to decide on an appropriate sentence and take the survivor's interests into consideration when sentencing the perpetrator. In addition, depending on what type of psychological effects and extent of the trauma the survivor has experienced, the report may be required for the purpose of making special arrangements in Court.

This report is usually written after a social worker has interacted with the victim/survivor for more than six sessions. Note that the social worker may be required to testify in Court as an expert witness on the trauma the survivor has suffered.

WHEN?

This report is compiled at sentencing stage or at any stage when the prosecutor or the Court requests it.

WHO?

Social worker

HOW?

Social workers have prescribed guidelines for compiling professional reports such as the Trauma Impact Report.

The responsible prosecutor requests a social worker to compile a Trauma Impact Report, which is based on the Amendment Act, 158 (a), 24 of 2003.

The social worker should ensure that this report contains the following details:

1) **A Cover Letter, which:**
   - appears on the Ministry's letterhead;
   - refers specifically to the paragraph in the report containing the recommendations; and
   - is signed by the person who verified the report, namely the senior, chief or control social worker.

2) **A summary of the professional's CV specifying:**
   - qualifications and experience relevant to the case not exceeding two paragraphs;
   - registration certificate as Probation Officer from the Ministry of Gender Equality, Poverty Eradication and Social Welfare and a registration certificate from the Social Work and Psychology Council (SWPC);
   - relevant work experience;
   - current employer/Ministry; and
   - position/capacity/rank (if applicable).

3) **Victim/survivor details**
   - Identifying details of survivor;
   - Family composition;
   - Particulars of the survivor; and
   - Relation to the accused.

4) **Introduction and Background**
   - Indicate details of the matter reported including when, how and by whom?
   - State how many sessions you have had with the survivor;
   - Specify the type of interventions (e.g. theories/techniques/assessments/therapy); and
   - State whether you are still seeing the complainant and when last you saw her/him.

HOW?

5) **Alleged Abuse**
   - Indicate the effect of the alleged abuse on the complainant;
   - Elaborate on any signs or symptoms of trauma;
   - Indicate whether any symptoms of PTSD are present – nightmares, eating disorders, sleeping disorders, substance abuse, enuresis (repeated inability to control urination) or encopresis (faecal incontinence or stool soiling), constant fear, mistrust, depression and suicidal thoughts/attempts; and
   - Mention actual changes in the complainant's life after the abusive incident (i.e. impact of the alleged abuse).

6) **Current situation of the accused**
   - Provide information about the accused's current situation;
   - Indicate the current whereabouts of the accused;
   - State whether his/her presence still poses a threat to the complainant and his/her family; and
   - Mention the biggest challenge(s) for the complainant and her/his family.

7) **Conclusion and recommendations**
   - State your professional conclusions; and
   - Indicate your professional recommendations.

Document Case Management Form 4: Alternative placement of a child

The CM4 document is used when a social worker recommends the removal of a child for placement in alternative care. It is completed within 45 days of receiving a referral or within 30 days if the child has been removed from her/his home. (The contents of the CM4 form is developed using information gathered from the Case Management form 1 and Case Management Form 2).

The CM4 thus provides an analytical summary of the findings of the social investigation (Form CM3), together with the social worker's details of key factors and a clear motivation to recommend the case to the Children's Commissioner.

Note that this report does not require any additional investigation or interviews.

Should the social worker determine that a child does not need protective services, she/he must inform the Children's Commissioner about assistance and interventional measures that will be taken to help the family.

These may include: Counselling, mediation, early intervention programmes, family reconstruction, behaviour modification, rehabilitation services or referral to another suitably qualified person. Such a recommendation is then made at a child protection hearing in court, which must be called within 30 days of completion of the social investigation.

p. Follow-up and Debriefing after Court Appearance

WHAT?

After the survivor's/witness' court hearing, the social worker has to follow up with the survivor and her/his family to debrief the survivor on her/his court appearance. This serves to explore the survivor's feelings, establish her/his expectations towards the Court's decision and provide emotional support if needed.

Follow-up counselling also serves to assess the survivor's progress towards the goals set in the care plan and to update the care plan if necessary.

Furthermore, the victim/survivor may be referred to other supporting services, which forms part of the ongoing identification of integrated case management opportunities through case conferencing.

WHEN?

After Court hearing

WHO?

Social worker

HOW?

A social worker who refers an adult or child survivor for services completes Case Management Form 5 to enlist the specialised assistance of another service provider who can complement the support she/he is providing.

Note that varying needs identified in a survivor's care plan may require the social worker to make several different referrals to other service providers. (The Case Management Form 7 is used for follow-ups and to update the survivor's care plan).

All contacts made with the victim/survivor or others involved in the case are therefore documented on Form CM7.

Remember that while the frequency of formal progress reviews will vary from case to case, all cases must be reviewed at a minimum of once every three months.

q. Court Standards for Case Reviews and Case Management

WHAT?

This occurs once a social worker has followed up and debriefed the survivor and her/his family after the Court hearing.

There are important procedures and standards that need to be followed for both case reviews and case management.

A. CASE REVIEW STANDARD: A formal process in which the multi-disciplinary team meets to discuss updates on all the issues ranging from safety and the criminal investigation to provision of services for the victim/survivor and her/his family (NCA 2013).

Rationale

Case review is the formal process that enables the Multi-disciplinary Team (MDT) to monitor and assess its effectiveness – independently and collectively – to ensure the safety and well-being of victims/survivors and their families. Its intention is to monitor current cases and is not meant as a retrospective case study. In this process, MDT members share their knowledge, experience and expertise so they can make informed decisions, nurture collaborative efforts, promote formal and informal communication, provide mutual support and review protocols and procedures.

Case reviews encourage mutual accountability and help to assure that survivors' needs are met sensitively, effectively and in a timely manner.

Case reviews should occur no less than once a month. Note that case reviews are not meant to pre-empt ongoing discussions, and ongoing discussions are not meant to take the place of a formal case review (NCA 2013).

The relevant police officers lead case discussion meetings.

Case Review Procedures:

- **Frequency of meetings:** Every month.
- **Members/attendees:** Medical officer, social worker, law enforcers (police and prosecutors) and mental health nurse/counsellor.
- **Designated coordinator to request meetings:** As the leader of the GBVPC, the relevant police officer acts as the coordinator to notify the MDT members about which case(s) will be discussed so that each agency is prepared to discuss them.

WHAT?

- **Case selection criteria:** This includes special cases, incest, gang rape or cases in which the perpetrator tested HIV+.
- **Meeting location:** Gender-Based Violence Protection Centre.
- **Meeting times:** These focus on not inconveniencing service provision.
- During the meeting, the attendees agree on who will follow-up on each of the issues raised.

The following elements should be discussed in each case (NCA 2013):

- Review interview outcomes;
- Discuss, plan and monitor the progress of the investigation;
- Review medical evaluations;
- Discuss witness/survivor protection and other safety issues;
- Provide input for prosecution and sentencing decisions;
- Discuss emotional support and counselling treatment needs of the survivor and non-offending family members as well as strategies for meeting those needs;
- Assess the family's reactions and response to the survivor's disclosure and involvement in the criminal justice/ survivor protection systems;
- Review criminal case disposition;
- Make provisions for court education and court support; and
- Discuss cross-cultural issues relevant to the case.

B. CASE MANAGEMENT STANDARD: Each Gender-Based Violence Protection Centre (GBVPC) must develop and implement a system for monitoring case progress and tracking case outcomes for all MDT components. Any new case tracking system must complement the existing tracking systems in Health, Social Welfare and Law Enforcement and not simply add to the list of existing tracking systems (NCA 2013).

Rationale

Case management is an important component of a GBVPC. Case tracking refers to a systematic method in which specific data is routinely collected on each case that the GBVPC serves (NCA 2013). Case tracking systems provide essential demographic information, case information and investigation/ intervention outcomes.

They can also be used to:

- Follow progress and provide alerts for each step of family assessments and case management; from tracking referrals to making sure home visits and follow-up visits have taken place;
- Allow MDT members to accurately inform victims/survivors and their families about the current status and disposition of their cases;
- Generate statistical reports;
- Do programme evaluation;
- Undertake quality improvement; and
- Informing strategies and design for effective primary and secondary prevention programmes.

Case tracking should comply with all applicable privacy and confidentiality requirements (NCA 2013), which include:

- Keeping manual records under lock and key, with a clear delineation of who has keys to the records; and
- Ensuring that electronic records conform to relevant Namibia laws and hospital policies on confidentiality and security.

Essential Components

Social workers are responsible for case management and should follow the latest MGECW Case Management Policy Manual.

A) The GBVPC/MDT's written documents include tracking case information until final disposition (NCA 2013).

WHAT?

B) The GBVPC tracks and is limited in its ability to retrieve statistical information from the Minister of Health (MOH) (NCA 2013).

GBVPCs are required to collect and demonstrate their ability to retrieve case-specific information for all GBVPC clients. This includes basic demographic information, services provided and outcome information from MDT partner agencies.

Statistical information from the Ministry of Health and Social Services (MOHSS) and the MGECW minimally includes the following data (NCA 2013):

- Demographic information about the victim/survivor and her/his family;
- Demographic information about the alleged offender;
- Type(s) of abuse;
- Relationship of the alleged offender to the victim/survivor;
- MDT involvement and outcomes;
- Charges filed and case disposition in criminal court;
- Survivor protection outcomes; and
- Status/outcome of medical and mental health referrals.

C) An individual is identified to implement the case tracking process (NCA 2013).

Case tracking is an important function of the GBVPC and can be a time-consuming task depending on case volume. Accuracy is important and for this reason, an individual is identified to implement and/or oversee the case tracking process. Some GBVPCs define case tracking as part of the MDT coordinator's or case manager's job. Some dedicate a part- or full-time position for data collection and database maintenance or assign the responsibility to an administrative assistant. Other programmes use trained volunteers who have signed confidentiality agreements to input data (NCA 2013).

D) All MDT partner agencies provide their specific case information and disposition (NCA 2013).

E) MDT partner agencies have access to case information as defined by the GBVPC/MDT's written documents (NCA 2013).

Because case data may be useful to MDT members for a variety of purposes, it is important that they have access to aggregate and/or specific case information. Policies should be developed regarding how this data may be released to participating agencies or parties other than the MDT that adheres to confidentiality requirements (NCA 2013).

WHEN?

Following the Court hearing and after the social worker has followed up and debriefed the victim/survivor and her/his family.

WHO?

Social worker

HOW?

The Follow-up and Case Review (Form CM7) should document each contact the social worker makes with the survivor or others involved in the case.

A review entails doing a more detailed assessment to ascertain whether planned goals have been reached, and, if so, whether the survivor's safety is assured.

It also includes any referrals the social worker may make on the victim/survivor's behalf to other service providers. The frequency of doing formal progress reviews may vary from case to case. However, all cases must be reviewed a minimum of once every three months.

Once the social worker has deemed that the victim/survivor is no longer at risk and all necessary support mechanisms are in place and functioning, she/he can close the case.

r. Follow-up Medical Care

WHAT?

All survivors of rape require medical follow-up to ensure their physical healing process is progressing and provide further medical services if needed.

Furthermore, follow-up is necessary to identify medical issues that might have been missed on the initial visit and to identify other infections with long incubation periods i.e. syphilis, hepatitis B and HIV seroconversion.

WHEN?

A follow-up visit is recommended at two weeks after the assault.

If the victim/survivor has received an HIV PEP, it is important to conduct an HIV test; including pre- and post-test counselling at intervals of six weeks, three months and six months' post-assault.

WHO?

Medical officer

HOW?

The following routine tasks should be performed as part of the two weeks' post-assault follow-up:

- Examine injuries only if the patient complains of pain or vaginal discharge;
- Check that the victim/survivor has completed the course of STI treatments; and
- Conduct an examination to assess the victim/survivor for persistent or new STIs and treat according to the National STI guidelines.

s. Case Closure

WHAT?

Case closure (using CM8, in the case of children) happens if all or most of the goals of the care plan have been reached. It should also be ascertained that the survivor or her/his family are able to meet the outstanding goals without further monitoring and follow-up visits. Before closing a case, the social worker must also ensure that the victim/survivor is safe from harm or threats, her/his care and well-being are being supported and there are no additional concerns.

A social worker may also close a case if the victim/survivor has moved away and lives in another district. In this situation, the social worker would only close the case and remove it from her workload after she has informed the social work colleague counterpart in the victim/survivor's new residential district.

WHEN?

Case closure happens when:

- The victim/survivor is safe and no longer needs protection; and/or
- The survivor is receiving adequate support elsewhere to meet her/his needs;
- The survivor no longer wishes to pursue the case and it is clear that she/he does so without any undue influence or intimidation or threat; or
- If the case is finalised at Court.

WHO?

Social worker

HOW?

Prior to closing the case (as identified in Form CM3) and updating relevant aspects over time, the social worker should conduct a final review.

In this review, the social worker does a more detailed assessment to establish whether the planned goals in the victim/survivor's care plan have been reached, and, if so, whether the survivor is now safe. Once completed, the case is closed.

REFERENCES

Combating of Domestic Violence Act, Act No. 4 of 2003

Combating of Rape Act, Act No. 8 of 2000

Combating of Trafficking in Persons Act, Act No. 1 of 2018

Common Law

Child Care and Protection Act, Act No. 3 of 2015

Clinical Management of HIV in Children and Adults, Namibia Integrated Guidelines for Providing HIV services 2011.

Criminal Procedure Amendment Act, Act No. 24 of 2003

Guidelines for Service Providers on the Combating of Rape Act of Namibia. Legal Assistance Center: Windhoek, Namibia, 2008. Available at: www.lac.org.na/projects/grap/Pdf/rapeguidlin.Pdf

Management of Sexually Transmitted Infections using Syndromic Management Approach – Namibia Guidelines 2002.

Married Persons Equality Act, Act No. 1 of 1996

National Guidelines for Antiretroviral Therapy, 5th edition (2016). Ministry of Health and Social Services, Republic of Namibia.

Prevention of Organized Crime Act, Act No. 29 of 2004

Namibia Government – The Namibia Police Service Survivor Support Training Manual

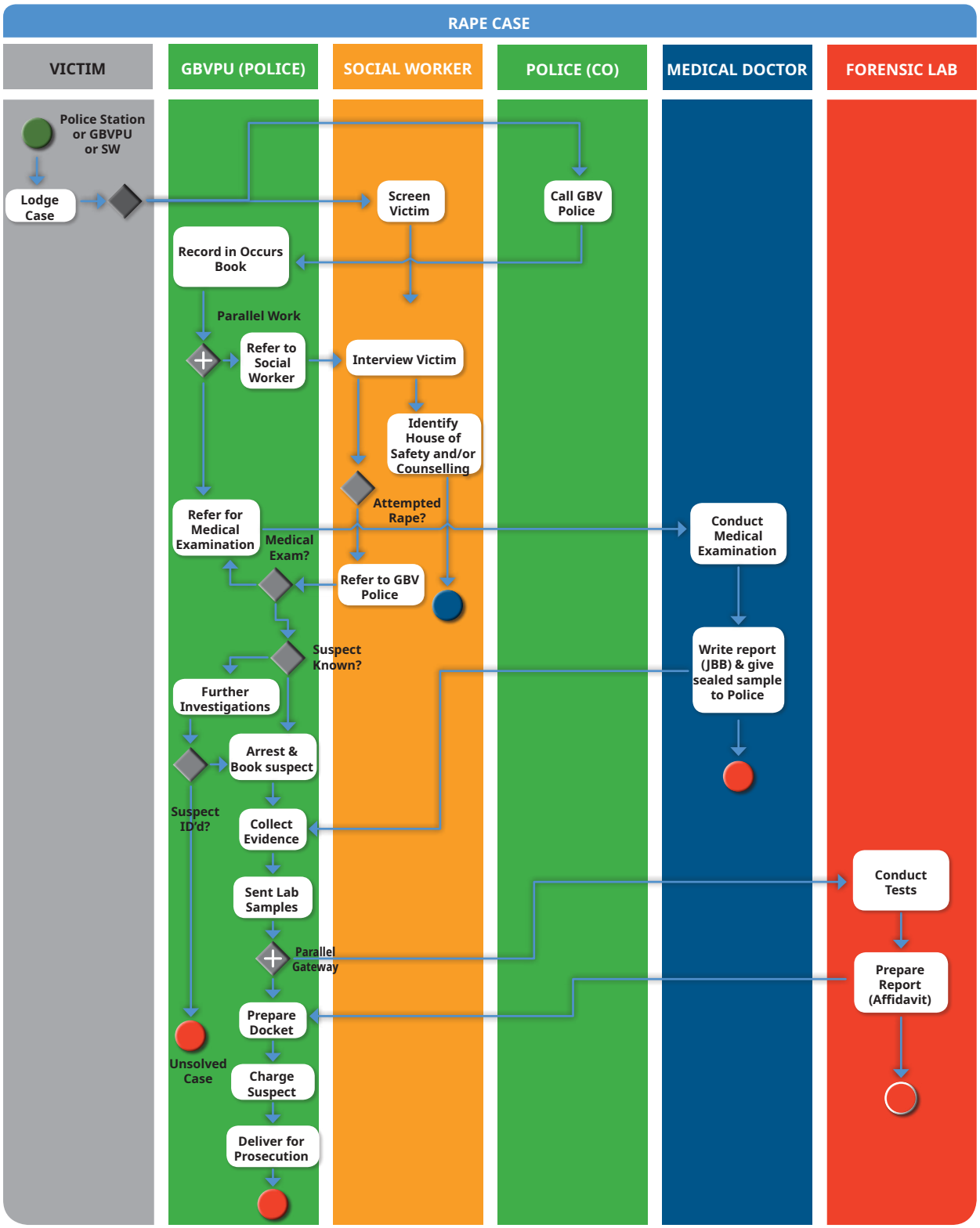
National Referral mechanism and Standard Operating Procedures for the Identification, Protection, Referral and safe return of victims of trafficking in Namibia, Ministry of Gender Equality and Child Welfare, 2018

Seeking Safety-Domestic Violence in Namibia and the Combating of Domestic Violence Act No. 4 of 2003. Summary Report. Legal Assistance Centre, 2012

Annexures

Annexure 1

SOPS Flow chart



Annexure 2

Treatment for Sexually Transmitted Infections (STIs)

For Adults:

- Benzathine penicillin – 2.4 MU intramuscularly single dose, OR Doxycycline – 100 mg PO bd for 14 days if allergic to penicillin;
- Ceftriaxone – 250mg imi single dose, OR Cefixime – 400mg PO STAT if available;
- Azithromycin – 1g PO single dose, OR Doxycycline – 100mg PO bd for ten days;
- Metronidazole – 2g PO single dose;
- Clotrimazole – 500mg intra-vaginal pessaries single dose.
  Contraception:
  - Ovral – 2 two tablets (levonorgestrel 150 mcg plus ethinyl estradiol 30 mcg) stat, then repeat after 12 hours; OR
  - Progesterone only (89% effectiveness): levonorgestrel 1.5 mg within 12 hours, but within not later than 72 hours; OR
  - A copper IUCD can be inserted up to five days after assault, even in nulliparous women.
- Metoclopromide – 10mg PO tds for five days. (The contraception pills may cause vomiting and nausea. If vomiting occurs within one hour of taking the pills, the dose should be repeated);
- Blood tests: HBsAb, B-hCG, RPR (Syphilis) and HIV.

For children:

- Metronidazole – 5mg/kg every eight hours for seven days;
- Benzathine – Penicillin:
  - < 25 kg: 600 000 Units imi STAT;
  - > 25 kg: 1,2 MU imi STAT;
  - > 45 kg: 2.4 MU imi STAT.
- Erythromycin:
  - < 8 years: 12.5 mg/kg PO every six hours for seven days;
  - > 8 years: 25 mg/kg PO every six hours for seven days;
- Ceftriaxone:
  - < 45kg: 50mg/kg imi do not exceed 125 mg imi stat for a child;
  - > 45kg: 250mg imi stat for child;

  Clotrimazole – 1% topical tds to vulva skin.

Tetanus Toxoid Schedule

Tetanus Toxoid should be given to all survivors of sexual violence (all ages/sexes) if there are any physical injuries of the skin and/or mucous membranes.

Dosing Schedule	Administration Schedule	Duration of Immunity
1st TT dose	At first contact	Nil
2nd TT dose	One month after first contact	1-3 years
3rd TT dose	Six months after 2nd contact	5 years
4th TT dose	One year after 3rd contact	10 years
5th TT dose	One year after 4th contact	20 years

Eligibility Criteria and Operational Considerations for PEP

Eligible	Not eligible
History of sexual assault where there is a reasonable chance of exposure to HIV.	Assault that occurred more than 72 hours ago.
Assault occurred less than 72 hours previously.	
Victim/survivor is HIV-negative on initial testing.	Victim/survivor who is HIV-positive on initial test (Refer to HIV Care and Services).
Victim/survivor and guardian consent to the treatment.	Victim/survivor or family does not agree to take PEP.

NOTE: The victim/survivor should be given PEP regardless of the status of the assailant as the assailant may be in his window period during the time of a negative test outcome.

The victim/survivor should receive PEP even if there are no HIV tests available to check her/his status.

Operational Considerations for HIV PEP

How to start PEP:

- Start taking PEP as soon as possible after high-risk exposure, within 72 hours;
- Avoid starting PEP more than 72 hours after exposure as it is not effective;
- If a victim/survivor taking PEP experiences side-effects such as dizziness, fatigue or paleness, she/he should return to the health facility for further assessment.

However, it is still important to do counselling and testing at baseline, six-weekly, three- and six-monthly intervals.

- Explain the dosage to the victim/survivor and stress the importance of adhering to the medicine regimen;
- Advise the victim/survivor to return immediately if side-effects are suspected;
- Advise any exposed adult to practice safe sex and use condoms until she/he is confirmed HIV-negative at the three-month check-up;
- Provide the victim/survivor with 30 condoms and re-supply as requested;
- Advise mothers not to stop breastfeeding; and
- Write all the victim/survivor's case details in the PEP register.

PEP follow-up

- These are done at six weeks, three months and six months; also repeat the HIV test;
- If found HIV-negative, the social worker can advise the victim/survivor that the exposure has not resulted in her/him being infected with HIV; and
- If the victim/survivor is found to be HIV-positive, HIV infection will be present during follow up; the social worker must then refer the victim/survivor for HIV care and support.

Dosages for Post-Exposure HIV Prophylaxis

- Be sure to start HIV PEP within 72 hours of any genital-genital or genital-oral contact;
- Start PEP even if the victim/survivor's HIV test is not available on that day, or if she/he refused to take the test;
- Schedule a follow-up HIV test in six weeks and thereafter in three months' time. Remember to write the appointment details in the victim/survivor's health passport.

The recommended antiretroviral regimen following rape is:
TDF + FTC (or 3TC) + ATV/r daily for 28 days.

Child survivors of rape who are <10 years old or <35kg cannot use the preferred adult PEP regimen. In such cases, replace TDF with ABC (or AZT if ABC is not readily available). In addition, for children <3 years old or <10 kg, replace EFV with LPV/r. (See dosages in Annexure 3).

It is recommended that a baseline Haemoglobin (Hb) reading be done only if the victim/survivor appears significantly pale before commencing PEP therapy, because of the risk of anaemia due to AZT. If a victim/survivor has an Hb = 8 mg/ml, AZT should be replaced in children (<35kg) with ABC and in adults with TDF.

In case of lack of availability of AZT, health care workers are encouraged to use their clinical judgment.

PEP therapy should be available at all health facilities and central medical stores. Each health facility should keep a bottle of PEP in a designated, secure unit that is easily accessible. Management should make all staff aware where the PEP medicine is kept.

Recommended HIV serology after exposure

Baseline (Day zero)	Follow up 1	Follow-up 2	Follow-up 3
Within 72 hours of exposure	Six weeks	Three months	Six months

If the victim/survivor is found to already be HIV-positive, then PEP should not be started. Instead, she/he should receive appropriate counselling and clinical referral.

All persons involved with rape survivors including the police, must ensure that the rape victim/survivor is brought to hospital as an emergency before detailed questioning takes place in order not to delay PEP initiation. Health care workers must make the decision about the need for PEP and not base this on the police report whether rape has occurred or not.

The need for PEP should be based on the following:

- A history of penetrative sexual assault;
- Penis-mouth or penis-anus contact; and
- Current HIV status.

Health care workers should counsel the victim/survivor on sexual abstinence and the use of condoms. Furthermore, they should stress the importance of drug compliance and provide comprehensive information on any possible side-effects.

Annexure 3

Assessment and Treatment Steps for GBV and VAC survivors

Process	Actions	By who and to whom?	Documentation Tool	
Step 1: Refer/Report client to the social worker	Alert local social worker that a child/adult may need support.	Any child, community member or service provider individually, or via the CCPF to a social worker or police officer. Reporting is mandatory for all professionals that have a concern about a child's protection and safety.	A verbal report is made immediately when identifying a concern. Complete **Form CM 1:** This involves reporting a client to a social worker. The report is done immediately after identifying a concern. ***Note that a written report is mandatory for professionals.***	
Step 2: Intake and Risk assessment	1. Intake: Social worker does an initial interview to record basic information about the client 2. Do a risk assessment to enable immediate emergency action if required. 3. Make a decision on the level of risk and appropriate action.	This is completed by the social worker based at the unit or a professional designated to deal with GBV/VAC cases.	**Form CM2:** Complete the Intake and risk assessment without delay, and no later than 48 hours after a report has been made as follows: **Part 1:** Compile a demographic profile, which needs ongoing updating. **Part 2:** Specify the presenting problem for any adult or child case. **Part 3:** Do a rapid risk assessment for any child at risk, and complete it no later than 48 hours after having made a report. **Part 4:** Determine the level of risk and next steps. **Part 5:** Case action. **Part 6:** Consent for case management. **Part 7:** Obtain respondent information.	
Step 3: Social investigation with care plan	1. Conduct a social investigation of any client deemed to be at medium or high risk. 2. Compile a joint development of care plan with child/ family and other key role players. (This can be developed while waiting for the court hearing).	Social worker with child, family and all other key role players, including police officials, prosecutors and relevant community service providers.	**Form CM3:** Social investigation **Part 1:** Client and case review **Part 2:** Social investigation **Part 3:** Child's voice/child wellbeing **Part 4:** Care Plan	Case conference record
Step 4: Court process, where required under CCPA	1. In cases of medium and high risk, a court report should be made when a court proceeding is required under CCPA.	Social worker, with support from her/his supervisor	**Form CM4:** Court Report In some cases, the Court Report must be ready for the court date. This must be fixed no more than 30 days after intake if the child is removed, and no more than 45 days if the child remains at home.	

Process	Actions	By who and to whom?	Documentation Tool	
Step 5: Referral, follow-up and case review	1. Referral to other support sources. 2. Ongoing identification of integrated case management opportunities through case conferencing. 3. Follow-up and review case to assess progress towards goals and establish if other services are required. 4. Update the care plan as needed.	Child, family (where appropriate), social worker and other role players	**Form CM5:** Bi-directional referral of a client for services **Part 1:** Referral of a client for services by another service provider **Part 2:** Receipt of client referral for services **Form CM6:** Case Conference Record **Form CM7:** Follow-up and updated action plan	Case conference record
Step 6: Case closure	1. The case can be closed once the child is considered no longer at risk and support mechanisms are in place and functioning.	Child, family (where appropriate) and the social worker	**Form CM8:** Case closure form	
Throughout: Case tracking	1. Ongoing case tracking and supervision	Social worker with her/his supervisor	**Form CM9:** Case tracking form	

CCPA Classification of Risk Levels in Child Maltreatment

Type of harm	High risk/Not safe – emergency response required (Illustrative examples)	Medium risk/Not safe – court proceedings or stay home	Low risk/Safe – referral for prevention/ early intervention
Violence (physical abuse)	Serious injury requiring urgent emergency medical attention Young child exposed to serious domestic violence	Harsh corporal punishment leading to bruises or emotional harm Child exposed to dangerous and reckless behaviour and/or domestic violence in home	No violence present Person causing violence has left the home with no plans for return
Abuse (sexual)	Child currently exposed to sexual contact with an adult (where the adult has ongoing access to the child) Child is being coerced into or has been abducted for marriage Child is accused of perpetrating sexual abuse	Child has been sexually abused in the past and received no support Child is in coercive sexual relationship with someone in position of power, e.g. teacher	Child and family have received support for previous sexual abuse and there is a protective adult in the home and no sexual harm factors present
Abuse (emotional)	Child is being persistently belittled, isolated, or humiliated by a significant carer or encouraged by carer, and child expresses wish to be removed from situation	Child is routinely exposed to belittling, isolation or humiliation Child is treated differently and worse than other children in home	Factors causing the emotional harm have been addressed (e.g. caregiver received support, change of caregiver) Abuser no longer has contact with the child

Type of harm	High risk/Not safe – emergency response required (Illustrative examples)	Medium risk/Not safe – court proceedings or stay home	Low risk/Safe – referral for prevention/ early intervention
Psychosocial distress	Child has attempted suicide or significant self-harm or is having serious thoughts about suicide Child is engaging in antisocial behaviour including violence, including being accused of perpetrating sexual violence	Child's social skills, ability to self-care and attend school are significantly impaired Child is regularly angry or depressed Child is periodically using drugs and/or alcohol	Child not displaying behaviours of concern The child has a significant carer who shows love and care openly to the child Child has experimented with drugs or alcohol, but is not using routinely
Neglect	Serious injury or illness due to neglect (e.g. malnutrition with no apparent cause, lack of support for HIV care) Lack of supervision exposing child to risk of serious harm, e.g. young child left alone with kerosene stove	Inadequate basic care Lack of supervision for young child or for extended period of time/child undertakes tasks beyond capacity Caregiver is emotionally distant Family is receiving child grant but child is not benefiting (grant abuse)	Child's basic needs are being met by the carer The child has a significant carer who shows love and care openly to the child
Exploitation and child labour	Child involved in worst forms of child labour (sex work, harmful physical labour – refer to employment legislation) Child is a victim of human trafficking	Child involved in sporadic labour or domestic work that interrupts schooling	The child is no longer working and is receiving support to return to school, etc. family is being supported so child is not at risk or having to return to work
Health issues and/or HIV	Child is extremely ill, is not adhering to ARV medications and has no HIV support Child is older than 12, but has not yet disclosed, is not taking ARVs and is defaulting from care Child is no longer attending school related to HIV Child is unware of own HIV status, is not taking ARVs and is in a sexual relationship with another	The child is questioning her/his health and needs to take ARVs and/or is struggling with adherence The child is being bullied at school about HIV Child has poor understanding of taking ARVs Child has recently disclosed and may be adjusting to status Disclosure plan and support needed	The child is medically stable with HIV. No barriers to HIV care or adherence Disclosure has taken place, but no pending needs at present or near future The child may benefit from proactive support, especially around making a disclosure plan with guardians

Annexure 4

Evidence of psychological effects of domestic violence

The Combating of Domestic Violence Act provides the following evidence regarding the psychological effects of domestic violence:

Section 31

(1) Evidence of the psychological effects of domestic violence is admissible in any proceedings held under this Act or under any other law, in order to prove –
   (a) That the act, which forms the subject matter of a charge of a domestic violence offence or an application for a protection order has been committed;
   (b) States the extent of the harm suffered by the complainant, to enable the Court to impose an appropriate sentence upon conviction of the perpetrator; or
   (c) Provides defences or grounds for mitigation of sentence in respect of the commission of a criminal act by a person who has suffered past domestic violence against the perpetrator of that violence.

(2) The Court must determine the weight to be attached to the evidence referred to in subsection (1) after such evidence has been heard, with due consideration to –
   (a) The qualifications and experience of the person who gives such evidence; and
   (b) All

Annexure 5

Definition of Domestic Violence

Section 2 of the Domestic Violence Act No. 4 of 2003 stipulates the following:

(1) For the purposes of this Act, "domestic violence", within the context of a domestic relationship, means engaging in any of the following acts or courses of conduct –

(a) Physical abuse, which includes –
   i. physical assault or any use of physical force against the complainant;
   ii. forcibly confining or detaining the complainant; or
   iii. Physically depriving the complainant of access to food, water, clothing, shelter or rest.

(b) Sexual abuse, which includes –
   i. forcing the complainant to engage in any sexual contact;
   ii. engaging in any sexual conduct that abuses, humiliates or degrades or otherwise violates the sexual integrity of the complainant;
   iii. exposing the complainant to sexual material which humiliates, degrades or violates the complainant's sexual integrity; or
   iv. Engaging in such contact or conduct with another person with whom the complainant has emotional ties.

(c) Economic abuse, which includes –
   i. the unreasonable deprivation of any economic or financial resources to which the complainant or dependant of the complainant is entitled under any law, requires out of necessity or has a reasonable expectation of use, including household necessities and mortgage bond repayments or rent payments in respect of a shared household;
   ii. unreasonably disposing of moveable or immovable property in which the complainant or a family member or dependant of the complainant, has an interest or a reasonable expectation of use;
   iii. destroying or damaging property in which the complainant, or a family member or a dependant of the complainant, has an interest or a reasonable expectation of use; or
   iv. Hiding or hindering the use of property in which the complainant, or a family member or dependant of the complainant, has an interest or a reasonable expectation of use.

(d) Intimidation, which means intentionally inducing fear in the complainant, or a family member or dependant of the complainant by –
   i. committing physical abuse against a family member or dependant of the complainant;
   ii. threatening to physically abuse the complainant, or a family member or dependant of the complainant;
   iii. exhibiting a weapon; or
   iv. Any other menacing behaviour, including sending, delivering or causing to be delivered an item which implies menacing behaviour.

(e) Harassment, which means repeatedly following, pursuing or accosting the complainant, or a family member or dependant of the complainant, or making persistent unwelcome communications, and includes but is not limited to –
   i. watching, or loitering outside or near the building or place where such person resides, works, carries on business, studies or happens to be;
   ii. repeatedly making telephone calls or inducing a third person to make telephone calls to such person, whether or not conversation ensues; or
   iii. repeatedly sending, delivering or causing the delivery of letters, telegrams, packages, facsimiles, electronic mail or other objects or messages to such person's residence, school or workplace.

(f) Entering the residence or property of the complainant, without the express or implied consent of the complainant, where the persons in question do not share the same residence;

(g) Emotional, verbal or psychological abuse, which means a pattern of degrading or humiliating conduct towards a complainant, or a family member or dependant of the complainant, including –

i. repeated insults, ridicule or name calling;
ii. causing emotional pain; or
iii. the repeated exhibition of obsessive possessiveness or jealousy, which is such as to constitute a serious invasion of the complainant's, or the complainant's dependant or family member's privacy, liberty, integrity or security; or

(h) Where applicable, threats or attempts to do any of the acts referred to in this subsection.

(2) For the purposes of subsection (1) (g), a person psychologically abuses a child if that person repeatedly –

(a) Causes or allows that child to see or hear the physical, sexual, or psychological abuse of a person with whom that child has a domestic relationship; or

(b) Puts that child, or allows that child to be put, at risk of seeing or hearing the abuse referred to in paragraph (a); but the person who suffers such abuse is not culpable in terms of this subsection.

(3) With the exception of harassment as described in subsection (1) (e) and emotional, verbal or psychological abuse as described in subsection (1) (g), any single act described in this section may amount to domestic violence.

(4) A number of acts that form part of a pattern of behaviour may amount to domestic violence, even though some or all of those acts, when viewed in isolation, may appear to be minor or trivial.

Annexure 6

Definition of Domestic Relationship

Section 3 of the Domestic Violence Act No. 4 of 2003 stipulates the following:

(1) For the purposes of this Act a person is in a "domestic relationship" with another person if, subject to subsection (2) –

(a) They are or were married to each other, including a marriage according to any law, custom or religion, or are or were engaged to be so married;

(b) they, being of different sexes, live or have lived together in a relationship in the nature of marriage, although they are not, or were not, married to each other;

(c) they have, have had or are expecting a child together, excluding situations –

i. where the child is conceived as a result of rape; or

ii. where the parties contributed gametes for artificial insemination, *in vitro* fertilisation or similar fertilisation techniques, but have no other relationship;

(d) They are parents of a biological or adoptive child; they –

i. are, or were otherwise family members related by consanguinity, affinity or adoption, or stand in the place of such family members by virtue of foster arrangements; or

ii. would be family members related by affinity if the persons referred to in paragraph (b) were married to each other, and they have some connection of a domestic nature, including, but not limited to –

(aa) the sharing of a residence; or

(bb) one of them being financially or otherwise dependent on the other; or

(f) They, being of different sexes, are, or were in an actual or a perceived intimate or romantic relationship.

(2) Subject to subsection (3), where a "domestic relationship" is based directly or indirectly on past marriage or engagement, past cohabitation or any other past intimate relationship, the "domestic relationship" continues for two years after the dissolution of the marriage or engagement, the cessation of cohabitation or the end of any other intimate relationship, but, where a child is born to any couple, their "domestic relationship" continues throughout the lifetime of that child or for two years after the death of the child.

(3) If, in an application for a protection order, a Court is satisfied that good reasons exist not to restrict the continuation of a relationship to two years as provided for in subsection (2), the Court may extend that period to exceed two years.

(4) For the purposes of subsection (1)(e), a customary union must be interpreted as giving to a relationship of affinity as if it were a civil marriage.

Annexure 7

Risk Assessment Forms

CM 1: Reporting of a client to a social worker | Part 2: Receipt for reporting

Please complete page 1 for any child or adult needing mandatory or non-mandatory social services

Date: DD / MM / YYYY **Date received:** DD / MM / YYYY

Contact details / address of the person reporting or referring client:

_____

_____

Dear Sir, Madam, Colleague,

I, _____(MGECW social worker name and title)_____, hereby acknowledge the receipt of

the report /referral on _____(client's name)_____, case number_____

for follow up services. We thank you for bringing this client to our attention.

We have reviewed the report / referral information and would like to inform you that the following actions will be undertaken:

□ Case is receiving attention and further investigations are being made: _____

_____

_____

_____

□ MGECW is able to, or has provided requested services: _____

_____

_____

_____

□ Did not provide requested services because (explain in brief): _____

_____

_____

_____

We value your interest in this client and sincerely appreciate your contribution to improving the lives of others.

Yours Sincerely,

_____ _____ _____

MGECW Social Worker Name Signature Official date stamp

Telephone:

Form CM 1: Reporting client to a social worker | Part 2: Receipt for reporting
To be completed by anyone making a referral to a MGECW social worker, page 3 of 3
November 2017

CM 2: Intake and risk assessment | Part 1: Client demographic profile

Part 1 MUST be reviewed at each visit/contact with the client and any change in information must be noted below, with a date when the information was changed.

Particulars of the person making the report / referral	**Reporting / referral date(s):** DD / MM / YYYY
Name:	Reporter: □ Self-referral □ Family/Friend □ Professional □ Other:
Professional title: Organization: Practice # *(if applicable):*	Contact information *(telephone / address)*:

Client Demographic Profile	**Intake date(s):** DD / MM / YYYY DD / MM / YYYY	**MGECW Ref #:**

Client's surname:		First name:	Home name (*If different):*
Date of birth: DD / MM / YYYY	Age:	ID:	Sex: □ Male □ Female

Marital status *(if applicable):* □ Single □ Married □ Cohabiting □ Separated □ Divorced □ Widowed

Address/ERF no/location/village/constituency:	Cell: Other tel:
Citizenship: □ Namibian □ Unknown □ Other:	Birth certificate copied: □ Yes □ No Home language:
Next of kin name: Relationship to client: Cell: Other tel: Address: □ Same as above □ Different (write below)	If student, school and grade: Best way to reach client or family: Child-headed household: □ Yes □ No

Previous history with MGECW: □ Yes □ No If yes, MGECW office: Social Worker:	If yes, other MGECW reference no.: When/Reason: File(s) located: □ Yes □ No
External support: Any other support and/or agencies working with client: □ Yes □ No If so, who/connection:	**Existing reference nos.** (if exists) □ Court □ Police criminal record □ Other, please specify:

Updates: Note any contact detail changes *(continue on blank page if needed):*

	DD / MM / YYYY		DD / MM / YYYY
	DD / MM / YYYY		DD / MM / YYYY
	DD / MM / YYYY		DD / MM / YYYY

Client surname / first name: MGECW Ref #:

Family information as applicable **Other(s) connected to the case/client** *(Use a blank page for additional space if needed)*			
Mother surname:		First names:	Date of birth: DD / MM / YYYY ID:
□ Alive □ Dead □ Unknown	Resides with client: □ Yes □ No	Cell: Other tel: Address *(if different)*:	Occupation: Monthly income:
Father surname:		First names:	Date of birth: DD / MM / YYYY ID:
□ Alive □ Dead □ Unknown	Resides with client: □ Yes □ No	Cell: Other tel: Address *(if different)*:	Occupation: Monthly income:

Other(s) connected to the case / client *(use a blank page for additional space if needed. For complainants and respondents, complete part 7)* Other children: □ Yes, how many?: □ No		
Surname:	First names:	Sex: □ Male □ Female
Date of birth: DD / MM / YYYY ID: School / Grade:	Contact info same as client: □ Yes □ No if not please provide:	Relationship to client:
Surname:	First names:	Sex: □ Male □ Female
Date of birth: DD / MM / YYYY ID: School / Grade:	Contact info same as client: □ Yes □ No if not please provide:	Relationship to client:
Surname:	First names:	Sex: □ Male □ Female
Date of birth: DD / MM / YYYY ID: School / Grade:	Contact info same as client: □ Yes □ No if not please provide:	Relationship to client:
Surname:	First names:	Sex: □ Male □ Female
Date of birth: DD / MM / YYYY ID: School / Grade:	Contact info same as client: □ Yes □ No if not please provide:	Relationship to client:
ANY OTHER ISSUES NEEDING SUPPORT/ATTENTION: *(Use a blank page for additional space if needed)*		
Completed by:	**Signature:**	**Date:** DD / MM / YYYY

Form CM 2: Intake and risk assessment | Part 1: Demographic profile
Can be completed by either MGECW Administrative Officer, client and/or social worker, page 3 of 14
October 2018

CM 2: Intake and risk assessment | Part 3: Rapid risk assessment

To be completed for any child who MAY be in need of protective services

Client surname / first name: MGECW Ref #:

Rapid risk assessment family profile and impact on client	Notes / supporting evidence
• **Family background and composition:** □ *Good / safe* □ *Recent changes (family income / wellbeing / household members)* □ *Challenges (unemployment / family breakdown / alcohol use)* □ *Unpredictable context (alcohol-related or domestic violence)*	
• **Parent/guardian health and wellbeing:** □ *In good health* □ *Health or wellbeing concerns but receiving support e.g. medication, disability support* □ *Fragile / regularly sick / inconsistent health* □ *Significant issues (e.g. chronic health issue, living with HIV, physical and/or mental disability, substance dependence)*	
• **Client relationships with immediate family:** □ *Good* □ *Non-existent / poor* □ *Inconsistent / unstable*	
• **Client relationships with extended family:** □ *Good* □ *Non-existent / poor* □ *Inconsistent / unstable*	
Client physical and social circumstances	**Notes / supporting evidence**
• **Client's physical health:** □ *In good health* □ *Health or wellbeing concerns but receiving support (medication, disability support)* □ *Health or wellbeing concerns requiring assessment / support* □ *Chronic health issue (HIV) See job aid 7* □ *Health vulnerability (disability, substance abuse, other)*	
• **Client's emotional health:** □ *In good health* □ *Health or wellbeing concerns but receiving support, (medication, disability support)* □ *Health or wellbeing concerns requiring assessment / support* □ *Significant Issues (poverty, suicidal, mental distress, negative thoughts towards self or others that could lead to self-harm or criminal activity)*	
• **Education:** *Feels safe at school:* □ *Yes* □ *No* □ *In school* □ *Poor attendance* □ *No longer attending school* □ *Never attended school*	

CM 2: Intake and risk assessment | Part 2: Presenting problem

Client surname / first name: MGECW Ref #:

Presenting / reported problem / Case type *(Check all boxes that apply; circle subcategory where relevant)*	
□ Abuse (physical / emotional) □ Abuse (sexual / rape / incest) □ In need of care or protection (neglect / maltreament / abandonment / orphan / baby) abandonment) □ Child living and working on the street □ Child Exploitation (child labour / child marriage / engaged in sex work / sexual exploitation) □ Child using alcohol / drugs □ Behavoural problems (uncontrollable harmful behaviours / other:) □ Child trafficking / abduction / kidnapping □ Child living in a home with (violence / alcohol / drug abuse) □ Child under 16 habitually not attending / in school □ Psychosocial distress (bereavement / trauma) □ Child-headed household / lacking suitable caregiver	□ Health (HIV infected / affected) *See job aid 7* □ Health and nutrition issues: □ Disabilities (physical / mental / psychological) □ Teenage pregnancy / young mothers □ Child in conflict with the law / victim in a serious crime □ Pre-sentence request / report □ Child witness support services □ Child living in poverty with insufficient food □ International social services or unaccompanied minor □ Place of Safety / Foster care / adoption □ Custody and guardianship (custody and access / custody and control / guardianship □ Children's home □ Child maintenance / grant misuse / benefit claims: GIPF / other: □ Other:
Violation / incident: □ Took place on a specific day □ Has been a long term /on-going concern	**Where?** *(Name of location, village, constituency)*
If on a specific day, date and estimated time of incident: DD / MM / YYYY HH : MM	If long term/ongoing concern, approximate date when problem started: DD / MM / YYYY
Has emergency action or intervention been taken? □ Yes □ No If yes, □ Police □ Emergency medical services □ Placement of safety / removal from home by social worker □ Other: Name of official, office, contact information:	
Presenting problem(s): *Please explain here* *For child justice clients:* Does child offender accept responsibility for crime charged with? □ Yes □ No *For GBV adult clients only:* • *Proceed to risk assessment if any children witnessed, were involved in this case and/or live with client* • *For cases where no children are involved or at risk, proceed to part 5 (page 8): next steps and action plan)*	

Client surname / first name: MGECW Ref #:

Physical environment	Notes / supporting evidence
• **Present living circumstances:** □ *Good / safe* □ *Okay / safe* □ *Inconsistent / varies* □ *Unsafe*	
• **Housing** *(type, size, ownership, impression):*	
• **Level of parenting supervision:** □ *High / good* □ *Non-existent / dysfunctional* □ *Inconsistent / varies*	
• **Food:** □ *Access to healthy food at least twice daily* □ *Inconsistent (e.g. often goes to bed without a meal)* □ *Significant issues (e.g. signs of malnutrition)*	
Child justice background	**Notes / supporting evidence in relation to criminal history**
Previous criminal behaviour / history *(check all that apply)* □ *Previous criminal behaviour (not resulting in arrest) (e.g. physical fighting, aggressive behaviour, petty theft, vandalism)* □ *Previous arrests* □ *yes* □ *no* □ *Previous convictions* □ *yes* □ *no* □ *Previous interventions (e.g. diversion, community service)*	
Any additional notes:	

Form CM 2: Intake and risk assessment | Part 3: Rapid risk assessment (use risk assessment matrix as a guide)
Must be completed by MGECW social worker, page 8 of 14
October 2018

CM 2: Intake and risk assessment | Part 4: Status of risk and next steps

Client surname / first name: MGECW Ref #:

Level of risk and next steps: *(Refer to Matrix and guidance on risk assessment and mark the relevant box with an X)*
□ **No / low risk (safe)** *Referral to others as needed with monitoring or address the situation as appropriate*
□ **Medium risk (safe at present, but potential for increased risk)** *Further investigation and support required while child stays at home.*
□ **High risk (not safe)** *Immediate action required to protect the child from harm such as physical violence, sexual violence, emotional violence, extreme neglect, exploitation and child labour, etc.*
Briefly explain your observations and reason for selecting option, with recommendations:

Form CM 2: Intake and risk assessment | Part 4: Status of risks and next steps
Must be completed by MGECW social worker, page 9 of 14
October 2018

CM 2: Intake and risk assessment | Part 5: Case action

Client surname / first name: MGECW Ref #:

Case action log / summary *(Summarize your intake, noting any actions and referrals made to other service providers)*

Actions done for this intake:

□ *Crisis management*
□ *Offered psychosocial support*
□ *Provided counselling / therapy*
□ *Offered information and resources*
□ *Assisted with care plan*
□ *Collaborated with stakeholders*
□ *Home visit*
□ *Other:*

Case status / recommendation:

□ Issues addressed, no follow up needed
□ Follow up needed, but social investigation not required
□ Social investigation and care plan required *(mandatory for all children with medium or high risk)*

Supervisor notes:

Social worker name:	Signature:	Date: DD / MM / YYYY
Supervisor name:	Signature:	Date: DD / MM / YYYY
Official stamp:		

Client surname / first name: MGECW Ref #:

Consent to receive case management services and support *(See Job aid 9)*		
The Ministry of Gender Equality and Child Welfare provides services and support so that all children are protected and cared for, and so that all families are able to provide care and support for their children. The following MGECW _____ Office, seeks to provide support / services to: _____ _____		
So that we know you have read and understood this agreement please answer yes or no to each of the following statements by placing a cross in the box.		
The information that you provide will not be shared with anyone unless: • You consent to the information being shared. Each time the social worker suggests that the information be shared you will have a chance to confirm your permission. • You or any of your children are likely to be seriously hurt.		□ *Yes* □ *No* □ *Yes* □ *No*
I understand that any social work court report filed will become public record.		□ *Yes* □ *No*
The above has been explained to me and any questions have been addressed.		□ *Yes* □ *No*
Name of client and/or guardian:	Signature:	Date: DD / MM / YYYY
Name of Social Worker:	Signature:	Date: DD / MM / YYYY

Organisation name, if any	**Contact person**	**Permission to share**	**Date**	**Client initials**
		□ *Yes* □ *No*	DD / MM / YYYY	
		□ *Yes* □ *No*	DD / MM / YYYY	
		□ *Yes* □ *No*	DD / MM / YYYY	
		□ *Yes* □ *No*	DD / MM / YYYY	
		□ *Yes* □ *No*	DD / MM / YYYY	

CM 2: Intake and risk assessment | Part 7: Respondent / complainant information

Respondents / Complainant can be alleged perpetrators, victims of crime or anyone needing to be interviewed around a case/investigation.

Client surname / first name: MGECW Ref #:

Information as applicable *(If more than one respondent / complainant, please use a separate form for each)*			
Surname:		First names:	Sex: □ Male □ Female
Date of birth: DD / MM / YYYY ID:	Occupation:	Cell: Other tel: Address *(if different from client):*	Relationship to client: Are they aware of complaint or case? □ Yes □ No
Date(s) of interview(s): DD / MM / YYYY ; DD / MM / YYYY			
Notes / observations by and on: Recommendations / actions: For GBV, were any children involved in, witness, or live with respondent / complainant? *(If yes, complete risk assessment)* □ *Yes* □ *No*			

CM 3: Social investigation | Part 1: Client and case review

Form CM 3 is completed for all clients who have been assessed using Form CM 2 and have been assigned to a social worker for protective services

Client and case review	**Date(s):** DD / MM / YYYY ; DD / MM / YYYY DD / MM / YYYY ; DD / MM / YYYY	**MGECW Ref #:**
Client's surname:	First names:	Sex: □ Male □ Female

Any changes in contact details? □ Yes □ No If yes, demographic profile section updated: □ Yes □ No

Describe any changes in living arrangements below:

Case Review *(Review intake and note additional information, updates, observations and / or causes for concern)*

Actions done during social investigation visit(s) :

□ *Crisis management*

□ *Offered psychosocial support*

□ *Provided counselling and therapy*

□ *Offered information and resources*

□ *Assisted with care plan*

□ *Collaborated with stakeholders*

□ *Home visit*

□ *Other:*

Client surname / first name: MGECW Ref #:

Client profile, strengths and challenges *(In review of Form CM 2, provide additional / more comprehensive details about client's circumstances. Explore and note strengths and challenges.*
Behavioural and psychological development
Emotional health and personality
Physical health *(including any HIV-related issues that are in need of support – see job aid 7)*
Education and school attendance / performance
Client's relationship with peers and others in the community
Leisure and recreational activities
Social, religious and cultural aspects

Client surname / first name: MGECW Ref #:

Family profile, strengths and challenges *(In review of Form CM 2, provide additional / more comprehensive details about client's circumstances. Explore and note strengths and challenges.)* *Copy this page for any prospective guardian arrangements if a separate assessment is required.*
Family background / composition / dynamics
Relationships *(including custody and access)* with parents / guardians / caregivers and siblings
Relationship with extended family
Housing and living situation
Financial circumstances *(employment, social grants, etc)*
Factors affecting overall sense of level of safety and care
Child's ideas for how to stay safe and make things better
If relevant to case, who does the child think they should be cared for by?
Parents / guardians / caregivers health and wellbeing
Does anyone in the household have any HIV-related issues that are in need of extra support?

Client surname / first name: MGECW Ref #:

Child's name:						**Date:** DD / MM / YYYY
Satisfaction Scale: *1 - Never / not at all*		*2 – Almost never*		*3 – Sometimes*	*4 – Almost always*	*5-Always*
Home and family	☹	😕	😐	🙂	☺	Notes / comments *(child's own words if possible)*
I feel safe at home	1	2	3	4	5	
My parents (or the people who look after me) listen to me and take what I say into account	1	2	3	4	5	
My parents (or the people who look after me) treat me fairly	1	2	3	4	5	
Warmth and affection: How often in the past week have you spent time doing the following things with your family?	☹	😕	😐	🙂	☺	
Talking together	1	2	3	4	5	
Having fun together	1	2	3	4	5	
Learning together	1	2	3	4	5	
Friends	☹	😕	😐	🙂	☺	
I have at least one good friend that cares about me	1	2	3	4	5	
My friends are usually nice to me	1	2	3	4	5	
How often in the past week have you spent time doing the following things with your friends, apart from school?						
Talking together	1	2	3	4	5	
Having fun together	1	2	3	4	5	
School	☹	😕	😐	🙂	☺	
I enjoy school	1	2	3	4	5	
I feel safe and supported at school	1	2	3	4	5	
Self	☹	😕	😐	🙂	☺	
I like the way I look	1	2	3	4	5	
I feel self-confident	1	2	3	4	5	
I have opportunities to improve my life	1	2	3	4	5	
Overall life satisfaction	☹	😕	😐	🙂	☺	
My life is going well	1	2	3	4	5	
I am happy	1	2	3	4	5	
feel positive about my future	1	2	3	4	5	

Client surname / first name: MGECW Ref #:

STRENGTHS-FINDER TOOL			
What makes me feel safe and secure	**Where am I already strong?**	**What makes it hard to be strong?**	**What would help in making things better?** **Where can I get support?**
How I grow and develop *Health* *Education* *Communication with important people* *Learning how to look after myself* *Being confident and being believed*			
What I need from the people around me *Providing guidance* *Providing stability* *Providing space to play and have fun* *Spending time with family and friends* *Being kept safe* *Providing everyday care and help*			
What I need from the outer world *Being able to go to school or training* *Having access to health care* *To feel safe in the community* *Knowing where to go when things are not safe* *Having a safe place to live* *Having enough money in the home*			

Client surname / first name: MGECW Ref #:

Care Plan: Identifying details of child		Date of completion: DD / MM / YYYY
Client's Surname:	First name:	Date of birth: DD / MM / YYYY
		Age:

Short term (next 3 months):	**Medium term (next 12 months):**	**Long-term (beyond one year):**
Client's goals:		
Parent / guardian / caregiver goals ***(if appropriate):***		
Social Worker's goals:		

CM 3: Social investigation | Part 4: Care Plan

Client surname / first name: MGECW Ref #:

Care plan actions and agreement: By signing the below, I agree to the following:

- *I have participated in discussions with the parties listed below and understand the written recommended actions. Any objections and/or disagreements are noted.*
- ***Client/guardian:** I agree for information directly related to this care plan to be shared, when necessary, with those cited or involved in this care plan meeting.*

  I understand that any information shared in a court report will be public record.

Care plan – agreed action plan	Responsible person and signature	Due date	Updates
	Signature:	DD / MM / YYYY	
	Signature:	DD / MM / YYYY	
	Signature:	DD / MM / YYYY	
	Signature:	DD / MM / YYYY	
	Signature:	DD / MM / YYYY	

Details of anyone who disagrees with parts of the plan and why:

CM 6: Case Conferencing

Client's Surname:	First name:	Date of birth: DD / MM / YYYY	Sex: □ Male □ Female
Date of case conference: DD / MM / YYYY		Type of case conference: □ Scheduled □ Unplanned	
Location of case conference: □ Child's home □ Office □ Other:			
Aim of case conference *(e.g. during assessment, routine monitoring, support):*			
Names of all family participants *(including children)*:			
Names & agencies of all non-family participants:			
Key discussion points:			
Key outcomes of meeting:			

Form CM 6: Case conferencing
To be completed by MGECW social worker, page 1 of 2
November 2017

Client surname / first name: MGECW Ref #:

Any observation on dynamics of meeting:
If the client is a child, did you have the opportunity to speak with the child whose case it is individually? □ Yes □ No If yes, what was the outcome of the discussion? If not, note date for follow up visit to child.
Next case conference or social worker follow up: Date: DD / MM / YYYY
Type, location, purpose / aim:
Signature of social worker: _____ Date: DD / MM / YYYY
I, _____ *(Client's name and / or parent / guardian / caregiver, as appropriate)* have read / been told the key decisions made at this meeting: Signature: _____ Date: DD / MM / YYYY
Supervisor Recommendations: Report reviewed and approved by: _____ *(Supervisor signature)* Date: DD / MM / YYYY

Form CM 6: Case conferencing
To be completed by MGECW social worker, page 2 of 2
November 2017

CM 8: Case Closure

Client and case review	**Date of completion:** DD / MM / YYYY		**MGECW ref #:**
Client's surname:	First name:	Date of birth: DD / MM / YYYY	Sex: □ *Male* □ *Female*
Client's current address:			
Case opening date: DD / MM / YYYY		Case closing date: DD / MM / YYYY	

Decision taken for case closure:	
□ *Goals met / issues resolved* □ *Client is lost to follow up (document all attempts made to reach client)* □ *Change in circumstances means client no longer in need of care and protection (e.g. client reunited with family and stable)* □ *Client turned a mature age* □ *The client and / or family no longer willing to participate (document all attempts made to engage client)* □ *The client has moved and case transferred to (note region, social worker):* □ *Other:*	**Summary from social worker of reasons for case closure:**

If applicable, confirmation of abuse / violation (determined outcome / conviction if known)

Client and/or child's parent / guardian / caregiver *(if applicable)* have been involved in decision to close case, or informed of decision if not present*:* □ *Yes* □ *No*

People Involved in final case closure meeting and details of the meeting:

Form CM 8: Case closure
To be completed by MGECW social worker, page 1 of 2
November 2017

Client surname / first name: MGECW Ref #:

Client and/or child's parent / guardian / caregiver (if applicable) know where to go and who to reach in case of further problems:

□ *Yes* □ *No*

Discussed and agreed upon follow up actions if ever need be:

Any additional information

I, _____
(client and/or name of child or parent/guardian/caregiver, as appropriate) have read / been told the key decisions made at this meeting:

Client and/or guardian signature: _____

Date: DD / MM / YYYY

Social worker signature: _____

Date: DD / MM / YYYY

Supervisor signature: _____

Date: DD / MM / YYYY

Official date stamp

Post closure updates / actions / supports (if applicable):

Social worker signature: Date: DD / MM / YYYY

Post closure updates / actions / supports (if applicable):

Social worker signature: Date: DD / MM / YYYY

Post closure updates / actions / supports (if applicable):

Social worker signature: Date: DD / MM / YYYY

Form CM 8: Case closure
To be completed by MGECW social worker, page 2 of 2
November 2017

NOTES:

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