TITLE OF THESIS:

THE PRACTICAL AND POLICY REQUIREMENTS FOR IMPLEMENTING POST RAPE CARE SERVICES IN RESOURCE LIMITED SETTINGS

THIS THESIS IS SUBMITTED IN ACCORDANCE WITH THE REQUIREMENTS OF THE UNIVERSITY OF LIVERPOOL FOR THE DEGREE OF DOCTOR IN PHILOSOPHY

BY

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Declaration

This thesis is the result of my own work. The material contained in the thesis has not been presented, nor is it currently being presented, either wholly or in part for any other degree or other qualification.

This study is an assessment of the process of investigating the requirements for, developing, and describing a set of interventions for delivery of post rape care services in three district hospitals (Thika, Malindi and Rachuonyo) in Kenya. This study was undertaken through the support of Liverpool VCT, Care & Treatment (LVCT) a local NGO in Kenya involved in HIV prevention, treatment and care research and programmes. LVCT hosted me, provided line management supervision and administrative support through the study period.

Data were obtained from health care providers in the three study hospitals, policy makers and practitioners in the Ministry of Health and the civil society in Kenya, from community participants and from routine clinical records of the survivors of sexual violence/rape who presented at the district hospitals during the study period. The study involved three distinct phases:

- A situation analysis phase: Development of the study design was supported by the candidates supervisors and data collection and analysis undertaken principally by the candidate with the support of research assistants
- An intervention phase: Development of an algorithm for delivery of post rape services was undertaken by the candidate. Development of clinical procedures for delivery of post rape care services was done in collaboration with physicians at LVCT and the district hospitals. Development of two training curricular and materials used to train i) clinicians and laboratory personnel, and ii) counsellors, during the intervention was undertaken in collaboration with the research assistant, counsellors and physicians at LVCT and the district hospitals.
- An assessment phase: This included documentation and reflection of the process of developing post rape care services, and a description of the uptake and delivery of services from information extracted from routine service delivery data. Data to describe acceptability of the services were collected by the candidate and research assistants.

Dedication

This thesis is dedicated to the most extraordinary family that I know of.

Monica & Paschal, you are the most amazing and inspiring parents.
Thank you for being there and for making me.

Nthemba, Kilonzo & Mulwa – the greatest siblings to have... yeah!

If I have another lifetime, I want to be born into this great family, yet again

Abstract

BACKGROUND: Many sexual violence survivors in Kenya access health sector services for treatment, preventive therapies and psychological support and delivery of primary evidence for the justice sector. I undertook a process to develop a set of interventions in response to limited health provider capacities, knowledge gaps in literature, and identified Kenya national priorities. This study was informed by feminist epistemologies and investigated the requirements for, developed, and described an intervention for delivery of post rape care services.

METHODS: In 2002, a situation analysis sought to describe perceptions on rape and establish priorities for post rape care services in three districts - Thika, Malindi and Rachuonyo. Sixteen focus group discussions (FGDs) with community participants (adult women and men, adolescent women and men) and 34 individual key informants (19 male and 15 female) with participants from health care facilities, VCT sites, religious institutions, legal organisations and police officers were undertaken. These results informed the intervention. A simple 'post rape care systems algorithm' was designed. A counselling protocol was developed. Health provider targeted training that was knowledge, skill and value based was provided to clinicians/laboratory personnel and trauma counsellors. The standard of care included clinical evaluation and documentation, clinical management, counselling and referral mechanisms. Between 2003 and 2005, data to describe uptake and delivery of services were collected prospectively from routine clinical records and analysed using EPI info. To describe acceptability, in-depth interviews were conducted with 37 purposively sampled health providers from casualty, laboratory, HIV clinics, records offices and the management at each hospital. Data were analyzed following the systematic framework analytical approach. My interpretations were informed by feminist perspectives.

FINDINGS: The situation analysis established diverse understandings of sexual violence, blurred boundaries between forced, coerced and consensual sex and, that social perceptions influence the uptake and delivery of sexual violence services. It also revealed lack of standards, policy, coordination, and service delivery mechanisms. The standard of care was delivered inconsistently. HIV PEP was not offered. During the implementation, 386 survivors were provided with care. 91 incomplete records were excluded from analysis. Of 295 survivors, 89% were female, 56% children. Median age was 16.5, (IQR 9, 25). 4 (of 119) children and 9% adult women were HIV positive at baseline. Of eligible survivors 88% received emergency contraception, 73% STI prophylaxis, and 99% initiated PEP. 72% survivors continued PEP, of whom 51% completed. 16% were lost to client flow system. 32% received 6-weeks HIV testing with 1 documented sero-conversion (female, 7years). 50% survivors initiated counselling, of whom 40% received at least 3 consecutive counselling sessions. Survivors receiving counselling appeared to be likely to complete PEP. All 42 (15%) survivors presenting >72 hours reported known assailants. Poor PEP adherence was linked to non-disclosure of sexual violence and HIV testing. Training improved provider skill and confidence and was described as 'important'.

CONCLUSIONS: The *standard of care* and *service delivery support systems* that were developed increased uptake. The *model for development of post rape care services* provided a framework on which care in resource-limited settings can be further evaluated and replicated. Training must be value-based and explore the normative nature of sexual violence and health provider gendered constructions and the impact on service delivery. PEP delivery should be optimized by increasing survivor retention for HIV testing and be utilised to leverage on-going HIV risk reduction while acknowledging the context of blurred boundaries between forced and consensual sex, and the impact of social factors on uptake, delivery of services and health outcomes such as adherence. Kenyan feminisms need to redefine a common consciousness and approach to 'culturally' sensitive issues.

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Acronyms

ART	Anti-Retroviral Treatment
DfID	Department for International Development
DHMT	District Health Management Team
DRH	Division of Reproductive Health
EC	Emergency Contraception
GAD	Gender and Development
JAPR	Joint AIDS Progress Review
KAO	Kenya Anti-Rape Organization
KNASP	Kenya National AIDS Strategic Plan
KNSSP	Kenya National Health Sector Strategic Plan
MOH	Ministry of Health
NASCOP	National AIDS and STI Control Programme
NGO	Non-Governmental Organization
PEP	Post Exposure Prophylaxis
STI	Sexually Transmitted Infection
SWAp	Sector Wide Approach
VCT	Voluntary Counselling and Testing
VHA	Vulnerability and Health Alliance
WHO	World Health Organization
WID	Women in Development

Acknowledgements

There is no way I can do justice to all those people who have been instrumental in my life during the life of this PhD, that I think at some point took a life of its own within mine. I am attempting to track the trajectory of my life starting when I began to toy around with the idea of a PhD -about 2001? and those of you who have been an instrumental part of this process - it's a little difficult to follow even for me... I just give it a shot..

Mwikali and Akinyi, from you I recognised that I have a responsibility to live my life. So, here I am...

The Kilifi 'crowd' - Tabs, Eds, Sassy, Sarah, Betty and Caz - you stars! Kevo (and for being brutally honest about what it takes do go this road!), Mike, Alan, Collins - cheers to 'Members & Roasters' and the inspiration I got from those Friday evenings...

Miriam, Sally, Sassy- you inspired and supported me tremendously. And then have never given me breathing space... this thesis is just but one tiny bit of the numerous results that I attribute to you all. Thank you.

Miriam (again), you gave me an education in commitment, just watching your passion and drive during the formative years of this work. And you still do...

Caroline Ajema Otieno. I could write a whole paragraph on you. You have stood the worst of my slave driving and we made a fantastic team. Nothing gives me more pride having been your mentor

My angel (am still searching - am not!?), Prince (what is your relationship with money?!!). Your emotional support sustained me through very rough times. And made me all the better a counsellor and a person. And Harriet - haven't we all soo grown? Be continuously blessed.

Catherine Masitsa, Judy Kimaru and Tabs (yet again) - I cannot over apologise for being a hopeless friend in the last three years. I will surely make it up. It is always an enriching and inspiring experience to be with you guys

The research teams and my colleagues at LVCT who were involved with me during the study, I cannot name you all here (I have already run out of space), but I will always be thankful. The research participants, whom I do not know personally, cannot be overlooked for their contributions to this process, although they may never know the difference not only to this thesis but to this country.

The DHMTs of Thika, Malindi and Rachuonyo - the support to getting this work done was amazing. Dr. Anisa and Dr. Ogolla, your interest made this process possible.

The DRH - particularly Dr. Kibaru and Dr. Solomon and my close working colleagues, Dr. Jilo, Dr. Meme and Kamanthe - the policy work would never have progressed without your involvement and facilitation

Al - I get the feeling that I will never learn as much from anyone for my professional growth as I have from you in the short time. I aim to have much of your leadership capabilities rub off on me, but in half the time ... ☺ cheers! And at the end, true to your style, you made a big exit. You will forever be fondly remembered

Ernie - even when you want to kill me, we still make 'the' formidable team. I hope we have learnt enough to maintain, respect and, 'sambaza' the spirit of true team work. Your support allowed me to slog through this process, with a full time job...

Annrita - sharing an office with you was an extra-ordinary experience in learning to be humane.

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Chapter 1 Introduction to the thesis

1.1 Introduction

In this thesis I present and discuss a process that involved Liverpool VCT, Care and Treatment (LVCT) and government health facilities in Kenya, in research investigating and developing health sector responses for survivors of sexual violence in three district hospitals. This study was premised on the understanding that social perceptions influence the experiences of, and responses to, sexual violence including those in the health sector. Two broad rationales informed this study: 1) perceptions of sexual violence in Kenya impact in health care delivery and uptake of care services and 2) the implementation of a set of interventions, re, health provider training and organizing a package of disparate services to deliver post rape care services, informed by an understanding of these perceptions could increase the uptake and delivery of post rape care services at health facilities, even in the context of limited resources.

Chapter one introduces the thesis. Section 1.2 describes the conceptual basis of the study highlighting the rationale, underlying aims and considerations that informed the study. The specific study aims in the form of a research question and study objectives form section 1.3 and a conceptual framework provided as figure 1.1. A background to the study (1.4) briefly explores the various discourses in health and development research and, policy and practice as applied in this thesis, including feminist epistemologies and gender analysis in health in the context of resource limited settings. An overview of the structure of this thesis forms section 1.5, with figure 1.3 providing a conceptual map. Operational definitions to draw distinction between the use of the term sexual violence and post rape care services among others are provided in section 1.5.1. The scope of this study is outlined in 1.5.2

1.2 Conceptualising this study

Survivors of sexual violence experience complex and multi-faceted health needs. Most people who have been affected by sexual violence turn to the health sector for clinical treatment, for the prevention of Sexually Transmitted Infections (STIs) including HIV, for pregnancy prevention and for psychological support, information and advice. Literature is increasingly making links between sexual violence and HIV/AIDS as explored in sections 2.5.1, 2.6. While this thesis focuses on health sector services delivery, it cannot be seen as entirely disparate from other

sectors contributing to prevention of sexual violence, legal and social services and restorative justice in what I refer to as the *'prevention, care and rehabilitation continuum'*.

The criminal justice system, for instance relies on the health sector to collect, analyse and document evidence and then support the delivery of evidentiary requirements in court, for it to function. Social services require support of health sector mental health and counselling services to adequately support survivors. Thus, the health sector sits squarely at the nexus of prevention, care and rehabilitation of sexual violence. It provides a key opportunity to strengthen the interface between prevention, treatment and care in the context of HIV/AIDS.

In spite of the centrality of the health sector, sexual violence was not always viewed as a public health or bio-medical concern, but as a social issue. Understanding the social constructions of sexual violence in Kenya was thus necessary for this study. Various authors[1-3] observe that violence of whatever nature (including sexual violence) is set into the social background of where it occurs and takes place within particular cultural contexts and environments. The social processes involved in the development of violent behaviour are components of the same social structure that produce resistance and determine how existing systems address these behaviours. In particular, Timbatemwa-Ekirikunbinza[2] identifies two primary predictors of violence as being sex and age. Thus, gender is critical to understanding the nature of, and responses of redress as they are socially located.

Social vulnerability to sexual violence has been framed in the context of unequal gender relations. In Kenya, the public debate on sexual violence was/has been located outside of the health sector, mainly within women's movements up until this study was undertaken. This debate primarily engaged in political activism for legislative action and policy changes, and focused on sexual violence against women by men. Chapter 3 maps out a trajectory that outlines challenges that were experienced in attempting to politicise and institutionalise legal and health sector responses. While the women's movement advocated for legislative and policy changes on sexual violence, it was not until the process of developing a post rape care service documented in this thesis that Government commitment and action has been experienced, with regard to health sector policies and practice. These issues are discussed further in chapter 9.

While focussing on health sector responses, I was convinced that understanding the social constructions of sexual violence in Kenya was necessary. To develop a better understanding of the associations between social constructions and institutional responses to sexual violence that I hypothesised impacted in the uptake and delivery of post rape care services. In addition, at the time (2002) gender inequalities were increasingly acknowledged as one of the main propellers for the HIV epidemic[4]. As a result of this advocacy (through the women's movements internationally), gender considerations in HIV/AIDS programming were gaining momentum (2.4.4). Understanding the social constructions using a gender lens provided an opportunity to investigate the possibilities of developing health sector responses that were gender responsive. Such an investigation permitted me to impact on the dual epidemics of sexual violence and HIV/AIDS. Thus, this research study was conceptualised within a framework of addressing both sexual violence and HIV/AIDS prevention and care. It is with this background that this research study was developed and this thesis written.

Other broad and underlying aims that influenced the design of the study were:

- To highlight the health related effects of sexual violence on survivors and the role of the health system in mitigating these
- To provide a platform for addressing sexual violence (a social issue) within the health sector given its centrality and mandate in prevention, care and rehabilitation. The highly visible and politicised nature of HIV/AIDS provided an opportunity for creating and strengthening this linkage
- To provide new knowledge that would support and stimulate development of concepts and models for comprehensive care services for survivors of sexual violence in the health sector that could be applicable to resource limited settings
- To stimulate dialogue and policy debate and action with regard to sexual violence

I selected a research question as the most appropriate way frame my overall goal. This was based on the nature of broad underlying aims, the need to draw on a broad range of policy and practice issues, and the choice of an intervention design in a context where I had limited control over the factors that potentially influenced the set of interventions[5]. This allowed me to question, observe and document a process that I was inherently part of (discussed in my reflexivity - 4.8). I developed two specific objectives guided by my two primary rationales and the third objective aimed at assessing the process of developing the intervention. In responding

to specific objective one, four sub-questions were asked in order to reflect the varied sets of priorities for delivery of services.

1.3 Study aims and objectives

Research question:

What are the practical and policy requirements for implementing post rape care services in resource limited settings?

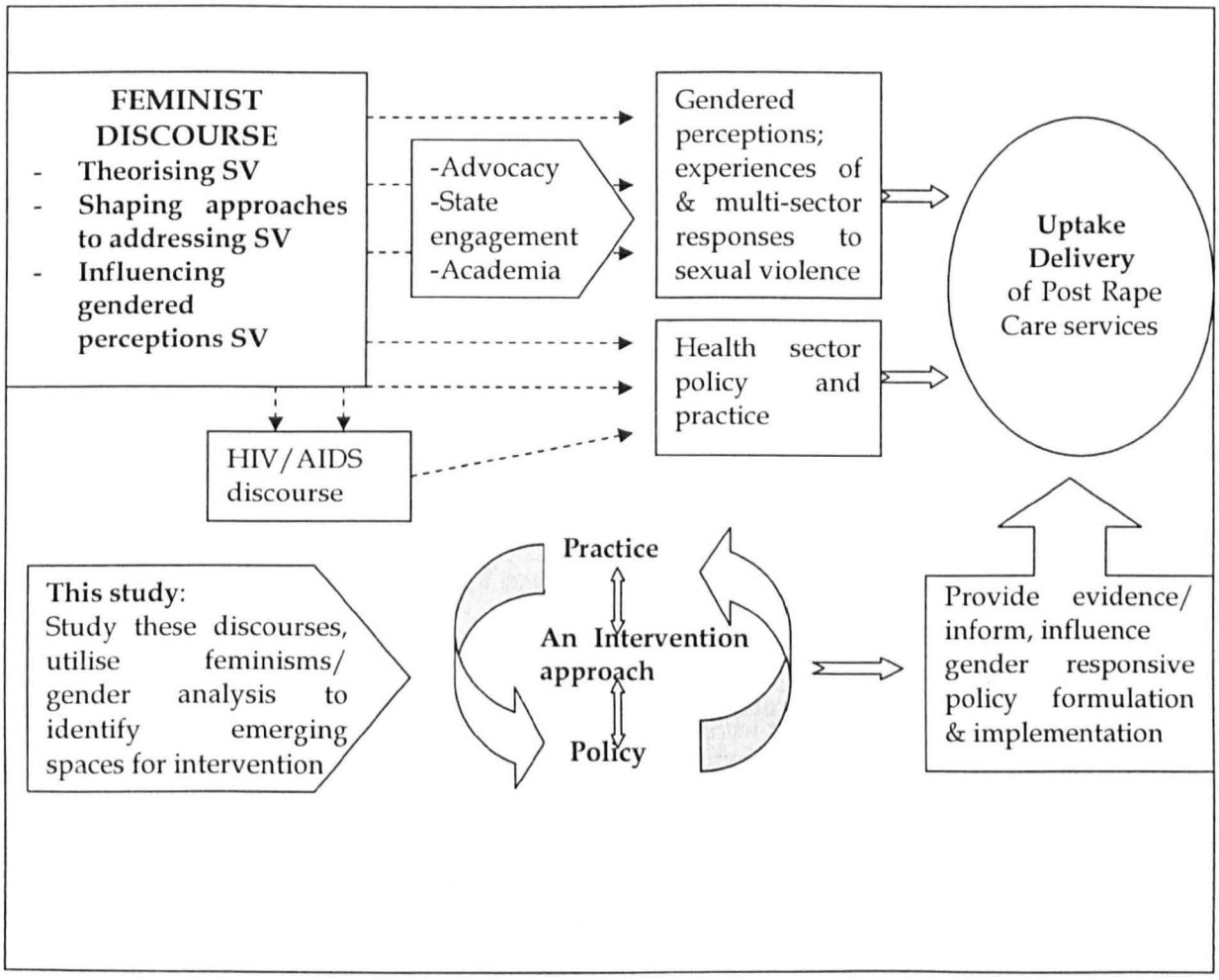
Specific objectives

1. ***To describe perceptions on rape and establish priorities for post rape services in Kenya***
   - *i.* ***What are the community perceptions of rape in Kenya?***
   - *ii.* ***What are the community/survivor perceived priorities for a good service?***
   - *iii.* ***What are the priorities for action by policy makers and the health sector in order to deliver a minimum standard of post rape care services?***
   - *iv.* ***What are the minimum standards for a post rape care service?***
2. ***To document the design and development of a strategy for provision of post rape care services in three district hospitals in Kenya***
3. ***To describe the uptake, delivery and acceptability of post rape care services in three district hospitals in Kenya***

1.3.1 The conceptual framework of this study

As described in section 1.2 above, this study was informed by an understanding of feminist discourses (explored in chapter 2) that theorise sexual violence, and have shaped perceptions and approaches to sexual violence and the HIV/AIDS through advocacy, state engagement and academia. These interactions are highlighted and linked to health sector programming and approaches as these influence delivery and uptake of sexual violence services. The links that this thesis attempts to make between this socially located discourse and health sector policy and practice are reflected. The aim of the intervention was to impact on experiences of, and health sector responses to sexual violence.

Figure 1.1 A conceptual framework of this study



1.4 Background to the study

This thesis draws and reflects on various discourses in health and development research and policy and practice including: feminist epistemologies and gender analysis. Feminist epistemologies provided a theoretical grounding to conceptualise sexual violence and a platform for historically understanding responses to sexual violence at international and local levels in Kenya. These discourses are outlined (1.4.1 - 1.4.2), followed by a description of additional practical tools adapted and utilised in linking social constructions and bio-medical perspectives on delivery and uptake of health sector sexual violence care services. I explain the adaptation of two tools that I drew on for their practical utility the 'vulnerability and health alliance framework' (VHA) and the 'ecological model of violence'.

1.4.1 Feminist epistemologies

Violence has been a central object of feminist analysis and theorisation and activism. Various strands of feminism (post structural, radical, multiracial feminisms) make different but overlapping postulations on sexual violence. While no single feminist theory on sexual violence exists, the varied perspectives place different emphasis on male power, patriarchy and gender relations in the society. Post structural feminisms focus on literary and discursive practices concerned with the way in which language in the form of discourses, shape domination and regulation. Marxist/socialist feminists see patriarchy and class as the organising principles[6-8]. Radical feminists have extensively theorised sexual violence and emphasize the centrality of patriarchy and masculine control of women, their labour and sexuality[9]. They see the control of women's bodies as central to existing gendered power struggles. Sexual violence is thus an extension of male power and domination over females. Multiracial feminism embraces the various strands of feminisms and examine how race, class, gender and sexuality in intersecting systems of domination rely on each other to function[10]. While the various strands, and particularly radical feminisms provide spaces for theorising sexual violence, they have been critiqued for their focus on the literary discourse[11], rather than on the lived experiences that appear to be fundamental to women's movements in Africa and a gender analysis has increasingly been utilised (2.4).

In this thesis I draw on multi-racial feminist theory and resonate with two stand-points. *First,* the spectrum of ideological and activist commitment to feminism is influenced by social positioning, which in turn impacts on responses to lived experiences. I visit this theoretical standpoint in my reflexivity in selecting the methodology for this study, but with less emphasis on the racial nuances for me, and more on the gender issues (4.8). I also utilise this theoretical perspective in analysing the social perceptions of sexual violence in Kenya that informed my development of the intervention (5.8). *Secondly,* gender is a basic social division, a power structure, and a focus of political struggle. The issues that shaped this stand-point for me emerged as I explored the trajectory of sexual violence in Kenya (outlined in chapter 3).

1.4.2 Gender analysis

Sen et al (2002)[12] refer to gender as,

> *"the structural inequalities marked by unequal access for women and men to material and non-material resources. This in turn forms the basis for defining and distinguishing male and female behaviour, expectations, roles and relations among women and men... it (gender) permeates social institutions as it refers not only to relations between the sexes at the individual level, but also to a complex array of structures, practices and behaviours that define the organisational systems that constitute human societies"(p6)*

Gender analysts have seen the normative use of sexual violence as a product of unequal gender roles and relations. In addition, institutional/structural and socio-cultural barriers are associated with women's social and biological vulnerabilities to sexual violence. Approaches that theorise the social production of ill-health have increasingly gained recognition as essential to designing health interventions. Farmer et al (1996)[13] see the interface between individual, communal and institutional factors that influence sexual violence and consequences such as HIV, as structurally determined and perpetuated. Thus, sexual violence responses in the prevention to care continuum require gender analysis, informed by an understanding of the biological, community related and institutional/structural barrier and/or factors of influence.

Most gender and health frameworks are however constrained in that they do not make links between social constructions and biological outcomes or bio-medical approaches in health care responses[14]. In this thesis, I argue for the utility of gender and health analysis in recognising

that gendered constructions impact on the delivery and uptake of bio-medical care for sexual violence. This is supported by increasing attention to gender and health equity analysis in health policy, planning and delivery[12,15,16].

1.4.3 Assessing the process of developing post rape care services

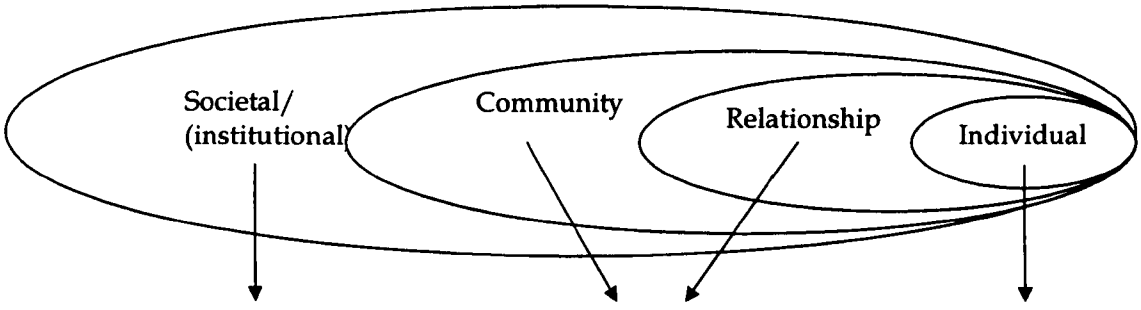
This study aimed to assess the process of developing post rape care services. I describe the set of interventions that were developed drawing on literature and outlining key processes, events and activities undertaken in consultations with health managers. The set of interventions included developing a standard of care, an algorithm, systems to support the delivery of the standard of care and capacity building for health providers (7.1 - 7.3). I use gender analysis and in particulalr 'gender mainstreaming' programming approaches to analyse the policy and practice implications of the interventions developed (chapters 6 & 8). The success of this set of interventions is described utilizing uptake, delivery and acceptability of services as indicators. These measures do not attempt to evaluate the post rape care service itself but describe and assess the intervention.

1.4.4 The Ecological Model of Violence

The ecological model of violence has been used to conceptualise sexual violence[17] (figure 1.2). It recognises levels of interacting influences on sexual violence linking the individual experiences of and responses to sexual violence to immediate contexts of relationships, social structures the larger societal socio-political situations. In recognising interacting hierarchical levels that influence sexual violence, it relates to the VHA framework. Its key advantages were: 1) in its specificity towards sexual violence and 2) its application of a gender lens, thus acknowledging the gendered nature of sexual violence experiences and responses.

Figure 1.2 The ecological model of violence[18]

(this illustration has been adapted to reflect on factors relevant for sexual violence)



• Women's lack of/ limited access to legal rights • Women's lack of access to health care • Poor criminal sanctions for SV • High levels of crime	• Weak community sanctions on SV • poverty • Traditional gender norms • Social norms that justify SV • Normative use of violence • Marital conflict • Family dysfunction • Economic stress & inequality • Early age at marriage • Family honour • Male dominance	• History of violence in family • Alcohol use • Young age (both women and men)

related influences of sexual violence that have negative health outcomes. In analysing institutional responses, it also fails to relate to health sector responses given their centrality to both prevention and care. The model therefore was constrained for sole use in this thesis in as far as it is not inclusive of bio-medical factors and approaches to examining and responding to sexual violence.

The Vulnerability and Health Alliance Framework

The vulnerability and health alliance (VHA) framework aims to capture and understand the complex and multiple factors that interact to influence vulnerability. The incorporation of bio-medical and social models of health into what has been described as a 'bio-social' approach allows the framework to capture complex interactions in health. Vulnerability has been defined as: *"A set of factors associated with an individual or group that increases their probability of experiencing a reduction in well-being (increased morbidity/mortality, decreased quality of life)"*[19][1]

[1] Adopted from The Vulnerability and Health Alliance, Liverpool school of Tropical Medicine

The VHA uses a multi-disciplinary approach that simultaneously embraces gender, poverty and bio-medical analytical lenses and identifies three levels of factors: 'the micro (individual/biological), micro/meso (household and community) levels and the meso/macro (environmental and institutional) levels. In its ability to link diverse approaches, the framework embraces the use of analytical lenses that are often used in isolation.

The use of a vulnerability approach in the context of this study provided an opportunity to identify complex and multiple factors that increase susceptibility of individuals to sexual violence and the associated negative health outcomes. Its broad nature provided spaces to examine cross-sector responses, which are discussed only in as far as they interact with the health sector in this thesis. The 'bio-social' approach taken by the VHA provided a platform to diffuse tensions between 'medical responses' and theories that prioritise the 'social production' of sexual violence located in feminist literature. In section 2.5-2.8, I utilise this approach to conceptualise the outcomes of sexual violence at each level of the VHA framework.

1.5 Structure of this thesis

Chapter 2 is a review of literature and briefly conceptualises sexual violence, outlining underlying feminist perspectives and the emerging tensions therein. Tiered levels of factors influencing sexual violence experiences and responses that fall within the prevention, care and rehabilitation continuum are analysed using the VHA framework, before focussing on the practice and policy considerations and concerns within literature for developing health sector responses in resource limited settings. A review of the theoretical foundations of the research methodology is described. Methodological challenges of sexual violence research are analysed as a basis for exploring the rationale for the methodology applied in this study.

Chapter 3 provides a background to the context of this study. An overview of geopolitical and economic indicators precedes a discussion of the extent and trajectory of sexual violence. The nature, structure and functioning of the health sector is described and gaps in response to sexual violence highlighted. LVCT, the research institution is contextualised and the organisation of the study sites outlined.

Chapter 4 describes the methodology - study design, rationale and limitations. Ethics and quality of the study are outlined before a reflexive section.

Chapter 5 presents findings of objective one focusing is on community perceptions of rape and sexual violence in Kenya. The voice in the discussions is that of myself, in my location as the researcher and influenced by theoretical and empirical literature.

Chapter 6 presents findings of objective one focussing on health priorities for action by policy makers and the health sector and the minimum standard of care for such a service.

Chapter 7 presents and discusses findings of objective two of the study. The process of design, development and implementation of a set of interventions is documented and explained. The process of development of a post rape care service is presented.

Chapter 8 presents findings from objective three of the study. Uni-variate analysis was used to describe profiles of survivors seen, uptake and delivery of services. Qualitative data used to describe the acceptability of post rape care services in Kenya are presented. I present my perceptions of this process, while aware of my being a constitutive part of the intervention process and therefore the interpretations will always remain open to multiple readings.

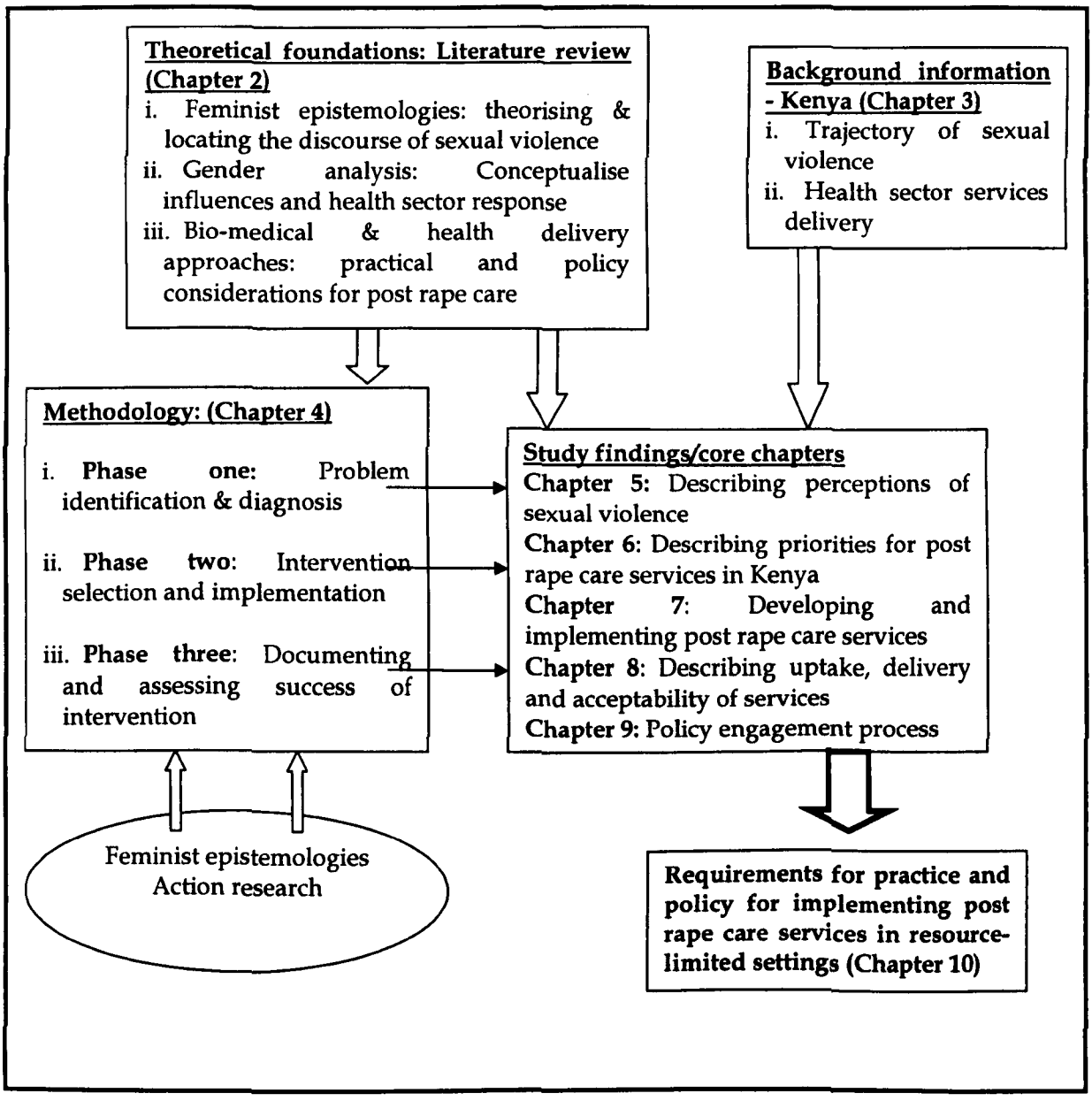
Chapter 9 describes the policy engagement process that was carried out during the writing up phase of this thesis. It was aimed at supporting institutionalisation of post rape care services within the Ministry of Health. This work was not located centrally in this thesis, but emerged as a critical area in response to the findings of chapters 5, 6, 7 and 8. This process is described in so far as, it directly utilised the study findings, it demonstrated the effects of this study, was relevant to the further development of post rape care services in Kenya, and it responded to the research question on 'policy requirements'.

Chapter 10 draws on the utility of the range of frameworks applied in this study and findings from the different objectives to discuss their implications and respond to the research question. I outline my new knowledge, gaps and priorities for further inquiry. Finally, I draw conclusions and recommendations.

Figure 1.3 below provides a conceptual map of the thesis showing relationships between the chapters. The theoretical foundations outlined in the literature review (chapter 2) informed the study design and selection of methodology (chapter 4) and the discussions of the study findings

(in chapters 5 to 8). The background of Kenya (chapter 3) also informed discussions of study findings and the policy engagement process (chapter 9). Approaches that informed the study methodology were drawn from action research and feminist epistemologies and are highlighted in the literature. The study findings and discussions feed into chapter 10 that answers the research question, outlines new knowledge added by this study and raises further research areas.

Figure 1.3 Conceptual map of the thesis



1.5.1 Operational definitions of terms used in this thesis

Sexual violence in this thesis is conceptualised using the definition provided by the WHO that is also made problematic by cross-cultural variations as discussed in 2.3.1. It encompasses the spectrum of coerced and forced physical touch or/and penetration of the perineal area, vagina, anus or mouth that has been defined variedly in the world. I utilise the term sexual violence in reference to these broad range of acts.

Post rape care services as used in this thesis refer to the health sector based services offered to survivors following sexual violence. The use of this term was identified at the initial stages of this study to draw specific attention to the health needs of survivors, drawing them apart from the broad range of services that would be required for justice and on-going rehabilitation that would be provided in the judicial, criminal justice and social systems. 'Post rape care services' was used with the understanding that 'rape' was narrowly defined in Kenya's legislation (3.7.1) and at the beginning of this study was identified as the most suitable term to draw attention to health sector care following sexual violence.

Children and adolescents: A child is defined as a person of below 18 years of age (Children's Act 2004).

1.5.2 Scope of the study

This sub-section outlines issues that emerged during the study that may have been relevant to this study but were not examined and described. At the beginning of the study they were invisible, or required more theoretical and pragmatic attention than was possible.

Survivors of sexual violence: Voices of survivors are lacking in this study although it was designed primarily to address their needs. At the beginning of the study (2002), there was limited knowledge of the numbers of survivors presenting at health facilities (3.9.2.2) and I was unable to determine the numbers that would potentially present as a result of implementing services (7.5.1). I therefore did not attempt to include survivors as study participants, instead had them as passive recipients of the service that was developed, based on literature of experiences elsewhere (2.4.4-2.6). Understanding the health care needs of

survivors, acceptability of services and the extent to which they benefited (and continue to) from the services developed remains an area of further research.

Sexual violence against men: During the beginning of this thesis, sexual violence against men was not in the public domain in Kenya. Thus this process was conceptualised in a context of sexual violence against women and located within a feminist discourse on the basis of the trajectory of sexual violence in Kenya. Between 2003 and 2006, there was emergence of reports and data on sexual violence against men (3.3.3). In the situation analysis, sexual violence against men emerged during focus group discussions (5.3.8). Thus, the primary purpose of section 5.8.4 is to briefly reflect on these findings. However, this thesis does not address the complex issue of sexual violence against men and is acknowledged as a gap and area for further research in Kenya.

Theoretical frameworks applied for this study: These have been described in sections 1.4 and further in chapter 4. The VHA framework aims to capture influences of vulnerability, risk and resilience. These aspects of the framework were utilised for their opportunity to identify causal factors, with an aim to explore the ways in which they influence uptake and delivery of services rather than for an analysis of vulnerability, risk and resilience. The framework was applied in relation to examining responses across the three levels (micro, meso and macro).

Chapter 2 The review of literature

2.1 Introducing the literature review

This review of literature presents debates that contextualise the research foci that are central to this thesis. Five main sets of writings are explored. The first set of the review conceptualises sexual violence (section 2.3) based on World Health Organization (WHO) definitions. It also maps out the extent (2.3.2) and costs of sexual violence (2.3.3). The second set of writings (2.4) broadly review feminist literature that has been used to study and understand sexual violence focusing on rationales offered by radical and multi-racial feminisms, emerging critiques and opportunities. The third set of literature conceptualises and analyses the influences on and outcomes of sexual violence, utilising the three categories of the VHA framework (micro, micro/meso and meso/macro). A gender lens is applied at all levels. This fourth broad set of literature is concerned with the policy and practical environment for the implementation of post rape care services. I link theoretical considerations in policy and programming for post rape services to available frameworks for health services delivery in the context of resource-limited setting, response to the HIV epidemic and with a focus on sub-Saharan Africa. Theoretical foundations of the methodology are reviewed and methodological issues in sexual violence research outlined (2.9). A section on the gaps identified (2.10.1), and the pertinence of this literature review to this thesis (2.10.2) is outlined.

2.2 Methodological approach to the literature review

This international literature review was drawn from two broad sources; published literature on sexual violence and care, including the use of HIV Post Exposure Prophylaxis (PEP), and implementation of health programmes in resource poor settings. The main databases searched were the World Health Organization (WHO) Bibliographic Database on Violence against Women and the PubMed database. Key words used included feminism, African/black feminisms, women, sexual violence/abuse, violence against women, gender based violence, gender and health, rape, HIV/AIDS, post exposure prophylaxis, emergency contraception, rape trauma, post traumatic stress disorder, health programming/es, health services acceptability/feasibility, health interventions in resource poor setting. These were used either

in varied combinations or in isolation. The meeting report on Violence against Women and HIV/AIDS: Setting the Research Agenda[4], formed a basis for discussion areas particularly in addressing objective one of the study. Other methods included hard searches and reference lists from secondary data.

'Grey' literature was reviewed. This included reports, guidelines and advocacy materials. It is important to search beyond peer reviewed journals and look at grey literature where much of the debate and exchange on sexual violence is located. It was strategic to access the views and priorities of practitioners and activists as this was central to understanding the opportunities and challenges faced in implementing post rape care services including HIV-PEP. Information from Kenya was primarily from unpublished works, organization reports and documents and the media. Information from and about Africa found on the internet was predominantly from South Africa. Research was largely from developed countries with the exception of South Africa.

During the course of the study, in September 2005, I also obtained literature from a WHO/ILO technical meeting to which I was invited. This was an expert consultation for the development of international policy and guidelines on occupational and non-occupational HIV-PEP. This meeting brought together experts (many are quoted in this literature review) on HIV PEP from around the world to review evidence and current practices in PEP provision and identify key policy, programming and delivery issues for PEP.

2.3 Conceptualising sexual violence: extent and costs

2.3.1 What is sexual violence?

Sexual violence is a form of gender based violence and has been defined as:

> *"any sexual act, attempt to obtain a sexual act, unwanted sexual comments and advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person irregardless of their relationship to the victim"* [20]

Rape and sexual assault have been used interchangeably to include the physical forced or otherwise coerced penetration of the vulva or anus, using a penis, other body parts or an

object[21]. However, there exists no single definition of rape as this differs by country, community and legal context. The lack of cross-cultural applicability of definitions raises concerns for international advocacy, research, surveillance and monitoring[22]. However, universal classifications/definitions are not always able to account for the variance and should be used with caution[23]. Sexual violence has been used to include coerced sex in marriage, dating relationships, rape by strangers and police, systematic rape during armed conflict, sexual harassment, sexual abuse of children, child marriage, forced prostitution and sexual trafficking and violent acts against the sexual integrity of women including female genital mutilations and obligatory inspections of virginity[24].

Sexual violence has increasingly gained recognition as a public health concern. It increases women's and men's long term risk to various health problems (pain, disability, drug and alcohol abuse and depression). Unwanted pregnancies result in unsafe abortions or injuries and complications from lack of follow-up care[25]. Of clear concern is the emerging evidence world-wide that such violence is an important risk factor contributing towards vulnerability, particularly to HIV and AIDS[26-28].

2.3.2 Sexual violence is pervasive

The true extent of sexual violence is unknown, though varied studies highlight its pervasiveness. In a multi-country study by the WHO on women's health and domestic violence against women, between 5% and 10% in the different settings reported forced first sex. Younger age at first sex was associated with the likelihood that sexual initiation was forced. Population reports (1999)[29] show that 66% of all sexual assault victims of all age groups across the world comprise of people 15 years or younger based on information from Chile, Peru, Mexico, Malaysia and Papua New Guinea. Available data suggests that one in three to five women may experience sexual violence in their lifetime. Much of sexual violence begins in childhood and adolescence with almost a third of adolescent girls reporting forced sexual initiation. In South Africa, 32% of 191 teenage mothers, reported that their first intercourse had been forced, 11% had been raped and 78% would be beaten if they refused sex[29-32]. Comparing figures for violence across studies is difficult due to variations in methodologies employed, questions asked and cultural biases in interpretations of violence. The complexities and challenges of undertaking sexual violence research are further discussed

in section 4.6.1 of this thesis and a deeper understanding of them informed the design of this study[33].

Conceptualisation of sexual violence as a 'private' rather than as a criminal and thus public issue, has constrained development of appropriate interventions. The most common forms of sexual violence are the most under-reported and occur within families, dating relationships, or where sex is acquired under coercion. Women's acceptance of violence as "normal" makes effective response difficult[31,34,35]. Rape often happens in environments of safety and at the hands of trusted individuals such as partners, employers, family members and neighbours[30,35]. Further, rape, like any other criminal activity is a part of the relationships in a society that become legally constructed as criminal. Avison (1974)[1] observed that criminal behaviour cannot be examined outside of the social relationships in a given context. Data suggests sexual violence by a partner to range between 10% and 50% across the world and to be as high as 56% in some settings[24,29-31,34-37]. A South African study showed that schoolteachers were responsible for 32% of disclosed child rapes[24,38]. Child rape is increasingly being given attention in literature. It has been suggested that 20% of women and 10% of men experience sexual violence as children[39]. There is also evidence that much of sexual activity amongst adolescents is coerced. The definitions of coercion are problematic[40,41]. However, limited formal research on sexual violence on children and adolescents exists on Africa.

It has been suggested that the risk of people with disabilities to be sexually violated is between one and a half to three times as high as amongst the non-disabled[42]. Most literature on people with disabilities is from the West. Disability is associated with increased physical and psychological vulnerability to sexual violence. Overprotection and internalised societal expectations of people with disabilities, and the limited opportunities available to learn to set boundaries for physical contact increases vulnerability to sexual violence. Virgin rape of people with disabilities has also been reported in association with HIV/AIDS in Africa[43].

2.3.3 The costs of sexual violence at individual and health sector levels

Limited research exists on the costs of sexual violence at personal levels. Costs to the individual have been estimated at 85,000$ in physical injuries, health care, legislative representation and protection and psychological harm[44]. A US study found that a history of

rape and sexual assault was a stronger predictor of subsequent physician and outpatient visits than any other variable and that their health costs amongst those with such a history were 2.5 times higher than those of other women after controlling for confounding factors[45]. Non-physiological outcomes of sexual violence have not been captured in theorising or estimating costs to individuals. Psycho-social effects, psychological consequences on self-esteem, productivity, well-being, behaviour changes have not been captured in the literature[44].

Macro-economic research has identified direct costs of sexual violence to the economy in medical and health systems (through increased morbidity and mortality), law enforcement and legal and social services[46]. All crime and violence together cost the equivalent of 5.0% of the gross national product of industrialized countries and as much as 14% of gross national product of low-income countries[44] and sexual violence form a part of these. .

Costing sexual violence is however problematic at individual and macro-levels. Under-reporting means that costs go un-captured but accrue in some way to the society or health systems through long-term implications. Economic losses related to productivity tend to be undervalued particularly in low income countries since these losses are typically based on foregone wages and income[44]. There are methodological challenges such as costing for psychological effects with difficulties in achieving consensus for economic values attached to human life, time, lost investments, productivity and quality of life. Varied data shows that indirect costs are generally significantly greater than direct economic losses incurred by survivors. Specifically commensurations for women's labour time loss who form a majority of survivors is problematic. The public sector and thus the society in general bears much of the economic burden of interpersonal (and sexual) violence through public financing or direct public expenditures with negative effects on investment and economic growth especially in low income countries (Miller, 1993 cited in Waters, 2004)[44]. There are limited evaluations of prevention interventions, potential effects on these programmes and the monetary benefits to accompany such interventions. However, all available studies suggest cost effectiveness of behavioural, legal and regulatory interventions[44]. With specific regard to HIV prevention, cost-effectiveness studies are limited by the need to include assumptions regarding per-contact HIV transmission rates and PEP efficacy for which there is limited data available.

With an understanding of the extent and costs of sexual violence, the following section reviews writings that theorise and analyse sexual violence.

2.4 Feminisms theorise sexual violence with varying epistemological trends

Feminist theorising on sexual violence has been introduced in section 1.4.1. In this section, I draw on writings of radical feminisms in particular as they have extensively theorised sexual violence[6-9]. I also make reference to multi-racial feminisms as they embrace various strands of feminisms and resonate with the experiences of African feminisms (discussed further in this section)[10]. They also provide spaces for examining diverse and contradictory gendered experiences, and are thus useful in exploring varied conceptualisations of sexual violence.

Seymour (1998)[9] sees men as socialised to adopt a 'predatory approach' to sexuality. Males with feelings of inadequacy, low-self esteem and poorly developed sense of self worth tend to use excessive degrees of dominance, control and authoritarianism. This gives credence to views that violence may not just be about male superiority and dominance, but about male vulnerability and the identity crisis of unachieved masculinity[47,48]. Sexualisation (the process of sexual socialisation) is seen to nurture female children towards accepting sexual violence later in life by boyfriends, lovers and husbands[9]. However, feminisms fail to sufficiently explain why many men do not rape or feel the need to exert their power and control over women, or to explain male rape by men and by women. Radical feminism in particular does not provide rationale for the agency and resistance of many women in varied settings. It seemingly implies static male and female personalities, suggesting fixed socialisation processes. However, Lancater & Lamb[7] see masculinity (and femininity) as heterogeneous and experienced in differing and contradictory ways by different groups of men, of women and as individuals. Socialisation and the ways in which it is expressed are continuously reproduced through actions in interaction with others and as a dynamic social structure[11,49,50].

Criticisms of western feminist writings on violence have emerged. *First,* the portrayal of men is seen as biased, representing white western hegemonic masculinities[51]. Various Western authors view the family as the macrocosm of patriarchy, where sexual violence is integral to

the cultural fabric as a tool for control and domination. For instance, Ward in Seymour (1998)[9] sees the rape of girl-children by a father as:

> *"an integral product of our society, based on male supremacist attitudes and organization, reinforced by fundamental social structure of the family" (p77).*

'African feminists' reject these perceptions of family and patriarchy, that are viewed as extremely individualist, with militant opposition and hostility to males. This is in a context where historical existence of communities is grounded in communal and familial interactions[52,53].

Secondly, the increasing post-structural nature of feminist theorising seems to ignore cultural and institutional settings in which the lived body experiences and responds to specific life situations[11,54,55], including sexual violence. Many 'African feminists' in particular perceive the focus on sexuality and 'the body' as secondary to the wider, public/personal issues of multiple oppressions found in gendered racisms, neo-colonialism and post-independence suppression of women's political autonomy[52,56]. The latter being an area that has largely shaped feminist approaches in Africa. Harnois (2005), in making a case for multi-racial feminisms suggests that the differences in priority of issues for African women's movements, coupled with their marginalization from the feminist movements may have resulted in a preference not to be labelled 'feminist'. Multi-racial feminisms take into account these differing approaches and debates and have been described as *"arguably... the most complete and nuanced of all feminist theories"*[10]. Thus, they seemingly provide opportunities for dialogue on the emerging differences between Western and African located feminists.

In the following section, I draw on these diverse perspectives and tensions to explore two key issues emerging for African feminisms with regard to addressing sexual violence. *First,* is the place of the African feminisms or women's movements as they are commonly referred in the broader feminist discourse. I briefly outline a historical background and the concerns and dilemmas therein (2.4.1). It provides a basis for understanding the discourse of sexual violence in Kenya discussed later in chapter 3. *Secondly,* sexual violence is conceptualised variously. Therefore, its visibility, socio-political location and the responses generated by it, vary widely (2.4.2).

2.4.1 'African feminisms' vary in philosophical and pragmatic orientations

After independence and the rural-urban migration of men in many African countries, women were confined to rural areas largely undertaking 'reproductive' activities. Feminist discourse, in the 1970s engaged the Women in Development (WID) paradigm and aimed at more efficient, effective development through integration of women in mainstream development. The first world women's conference was held in Mexico in 1975 and provided the beginnings of an operational framework for a global feminist movement. The UN 'women's decade' (1985 to 1995), was launched at the 'Nairobi Forward Looking Strategies' (NFLS) in Kenya, a decade later. During the decade, the Gender and Development (GAD) approach superseded WID in being more concerned with power differences that underpin gender inequalities versus the integrationist approach used in WID. GAD as a policy and planning approach however presented complexities in terms of practical applications and transformation of societal values and attitudes that are discussed next.

To address the challenge of the practical application of GAD, gender mainstreaming was adopted officially at the 'Beijing Platform for Action' in China, 1995, at the end of the UN women's decade. Gender mainstreaming requires that gender concerns and perspectives are analysed and visibly addressed in all policies and programmes at planning, implementation and evaluation[57]. A potential weakness of the mainstreaming approach was identified as its focus on analysis with policy statements remaining at the national level on paper with limited implementation[57,58]. National commitments therefore disappear in what Derbyshire (2001) referred to as 'policy evaporation'[59]. Moser (1993)[58] identifies the lack of technical capabilities and simplified tools for planners to use in gender mainstreaming efforts. Theobald et al (2005)[60] highlight the difficulties of mainstreaming gender. Key concerns include *"whether it is a strategy or a set of tools, what its final goals are (and) how to evaluate it..."* (pp:143). They adopt the concept of *'strategic framing'*[61] as a means of applying gender mainstreaming. Strategic framing centres on understanding the varied location and positionality of each actor that influences spatial strategies and resources employed for gender mainstreaming. Thus, different feminists and gender advocates seek to use their specific platforms diversely to ensure that gender considerations are integral to their areas of operation. For instance, with

specific regard to sexual violence, advocates working in the health sector have strategically influenced WHO's policies and programmes to adopt violence against women as an area for international attention and commitment through research, policy formulation and provision of operational guidelines for action (as described in section 2.4.4).

With regard to the transformative value of the GAD approach, interventions focused on the necessity for gender equality and information and awareness creation for attitude change[62]. Advocacy in the form of education on social issues and women's rights issues was mediated by women's grassroots and national level organisations. Many women chose to term themselves as gender activists/advocates rather than feminists, in departure from Western located feminist priorities[63]. They focused on interrogating gendered oppressions in socio-political and economic spaces and educating the public on importance of gender equality[52]. Ngugi (2000)[64] however, questions the inherent assumption (as used in these approaches) that knowledge that gender equality is desirable, translates to belief and thus commitment to action. She asserts that understanding the disconnect between knowledge and belief presents

> *"...a distinction of supreme importance when considering strategies used by the (women's) rights movement and their relative impact" (pp13).*

Engagement with the concept of feminism in Africa is an on-going debate. In attempting to define African feminisms, literature identifies many groups with varied philosophical and pragmatic orientations. There exist diverse geo-political and cultural contexts, further complicated by the existence of relative dichotomies between 'the modern' and 'traditional' woman. This is actually a broad continuum that spans associations with largely traditional frames of reference, to those of 'elite' women engaged in overtly political work, and those straddling both areas. Scholars continue to question the relevance or appropriateness of feminist movement in the African context [65-67]. This is in view of on-going debates as to what is 'culturally' and socially valuable within the complexity of differing interests, priorities and perceptions.

2.4.2 Definitions and understandings of sexual violence in Africa

Sexual cultures that characterise much of sub-Saharan Africa show high levels of pre- and extra- marital relationships[67-69]. Reference to 'African' can be problematic due to the

diversities within, Leclerc-Madlala (2005)[68] notes that in most traditional societies, male and female extra and pre-marital sexual activity was not sanctioned and this has extended to present day society. Sexual access for women was also allowed and tolerated with varying degrees of discretion. Traditional frames were characterised by certain levels of openness amongst age and gender defined sets of people and much of initiation activity was organised around sexuality. Sexual activity has increasingly been defined by new gendered post-colonial arrangements and changed social, political and economic environments. Emerging forms of sexual activity include transactional sex amongst young girls and increased sanctions against women's sexual experiences pre and extra marital sex. In addition, introduction of Christianity and Islam has bound sexuality with religious belief systems that imply sinfulness, hence attempts at sexual repression[68]. Studies however continue to show that pre-marital and multi-partnered sex among the young is still regarded as natural, an expression of love. For instance, in a study of 8,811 respondents in Nigeria, 26% male and 28% female reported sex with casual partners at least once in the preceding month[70].

Within this context are varied conceptual understandings of sexual violence. In some communities, the belief that a man has a right or even duty to force himself on a woman who displays reluctance is common to both men and women. In these instances, this was and still is often seen as a sign of affection. In other settings, a woman was expected to fight off a man, who in turn has to fight her and eventually have sex with her as a show of strength. Therefore acts of forced sex in these communities are not necessary perceived as sexual violence. The nature and structure of the African family has also taught men that relations with one woman only are not part of man's nature[70]. These traditional frames have been challenged as working within power structures to reinforce women's subordination[39,68,71].

What remains clear is the sanctioning against of child rape by both traditional and modern frames. Jewkes (2005)[72] explains this seeming consensus as linked to acts of self preservation where child rape is seen as symbolic of a *"threat... to the moral order of society"* (p1809). However, this consensus is constrained by the varied definitions of a child that are contextual and the differing practices of acceptable sexual play between adults and children that creates fuzzy boundaries.

2.4.3 Emerging opportunities for delivering post rape care services

Drawing from this literature, I suggest that sexual violence is at the nexus of two tensions. One is the tension between the traditional/modern conceptualisations of sexual activity- i.e. what is defined as sexual violence within the varied traditional interpretations and what is defined within modern frames such as legal and public health frames as provided by the WHO. The *second* is the interactions of social power structures that sanction sexual behaviour in ways that reflect neither traditional frames nor emerging modern conceptualisations. These varied understandings and restrictions present challenges for defining and designing interventions and could potentially influence uptake of post rape care services. In addition, the influences of these tensions on the debates of sexual violence in Africa have not been analysed.

However, there are emerging opportunities offered in the advocacy and increasing convergence of a global feminist movement against sexual violence[73]. Attempts at developing cross-cultural conceptualisation seem to be located in the legal (human rights) and health sectors. For instance, feminists/gender advocates within the health sector have engaged with the WHO and a conceptual definition, research strategies, and operational frameworks for addressing sexual violence have been developed. Sexual violence has been defined in the WHO report on violence and health[74] and in the WHO multi-country study that documents prevalence, health outcomes and responses[75]. The Sexual Violence Research Initiative (SVRI [http://www.who.int/svri]) was set up by the Global Forum for Health Research and the WHO to promote sexual violence research and to generate empirical data to ensure that sexual violence is recognised as a priority public health concern.

The WHO guidelines for medico-legal care for victims of sexual violence[76] provide detailed literature. They first outline the prevalence, dynamics and consequences of sexual violence, discussing risk factors drawn from the ecological model of violence (figure 1.2) and myths related to sexual violence. They then provide guidance on recommended services outlining consideration for priority services such as prophylactic treatments for HIV, STIs and pregnancy, ethical issues of autonomy, beneficence, non-maleficence and justice and, interaction of services within the prevention care and rehabilitation continuum. These

include counselling services, laboratories, health facilities, police and the criminal justice system. Medical management procedures include history taking (general, gynaecological and assault history), physical examination ('top-to-toe' examination and genito-anal examination), recording and classification of injuries (injury description, wounds classification, injury patterns and their interpretation). Details of forensic specimens to be collected, procedures and techniques of collection are provided, in addition to details for analysis. Follow up care includes STI testing, HIV testing, provision of Hepatitis B toxoid and vaccination, medical review, counselling and social support and referrals. Child sexual abuse is categorised separately with operating procedures for treatment and follow up. Documentation and reporting details include, how and what should be documented, storage and access to records, photography, delivery of written evidence and court attendance and epidemiological surveys.

Complementary literature (both grey and published) provides additional ideas and/or questions relevant to care. Kim et.al (2003)[77] outline key ethical considerations for PEP delivery in South Africa including informed consent, HIV testing at the consent of the client and not a pre-requisite for PEP. However, they raise queries regarding counselling needs for HIV PEP uptake and training and monitoring system needs for delivery. Kerr et.al (2003)[78] documents the experience of setting up a one-stop pilot facility in London outlining active follow up and referral systems in addition to the medical management and counselling services provided. Various aspects of care, treatment, counselling and follow-up following sexual violence have been documented[79-82] but none provides the broad range of services suggested by these WHO guidelines and the WHO policy guidance framework[83]. Additional information on setting up post rape care services has been provided by the South African Gender-Based Violence and Health Initiative[84]. They suggest the need for starter packs for HIV PEP for survivors, and suggest that the National Health Office should provide for a gender-focal point to support GBV integration, with responsible persons appointed at local levels. The International Planned Parenthood Federation[85] recommends routine screening of all women presenting in health facilities for sexual violence. The lack of capacity for on-going support and/or shelters has been identified as a challenge to routine screening approaches[4].

2.4.4 Contextualising sexual violence theorising and health sector response

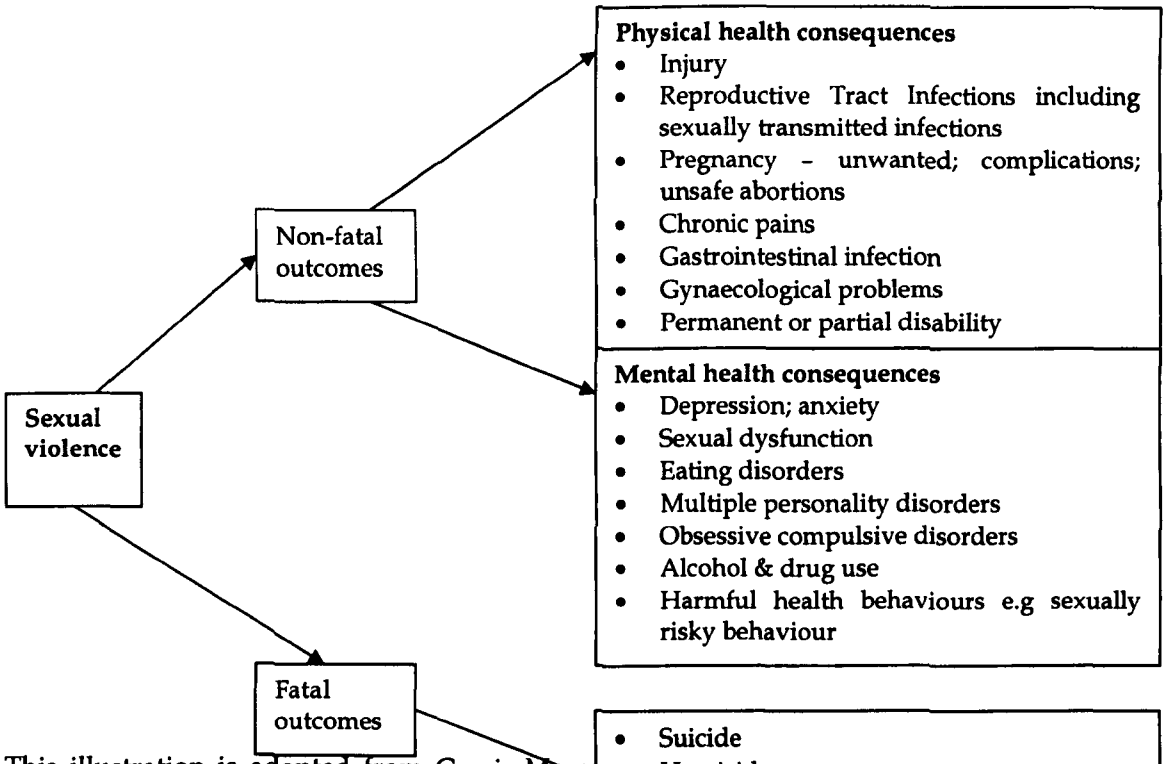
In the previous section, I have explored feminist writings as a basis for theorising sexual violence and highlighted emergent tensions and concerns. Theorising sexual violence and the positioning of African feminisms provided a background on which to explore the intersections between the causes/vulnerability factors and health care responses and outcomes of sexual violence.

In the following section, I frame the exploration of literature that focuses on outcomes within the VHA framework (2.5 - 2.9) and complemented it with the ecological model of sexual violence as described in section 1.5. *First,* I explore the disease related outcomes of sexual violence, as they have been identified in literature. I examine the responses that have been prescribed from a bio-medical perspective (2.5.1-6). *Secondly,* I locate the meso level factors that potentially influence responses to sexual violence including uptake and delivery. *Thirdly,* I examine the macro level responses and contextualise the structure and functioning of the health sector as the expected area of response for the micro level outcomes. I utilised the opportunity presented by these range of frameworks to diffuse the tensions between 'theories that prioritise the social production of sexual violence (as located in feminist theorising) and the medical responses' (1.5.1).

2.5 Conceptualising micro level (biological/disease) outcomes of sexual violence

Biological influences are concerned primarily with the negative health consequences of sexual violence. In this section, I explore the issues, concerns and challenges for appropriate responses within the prevention to care and rehabilitation continuum. I utilised the health consequences of sexual violence as framed in figure 2.1 to examine micro-level/biological related outcomes.

Figure 2.1 Health consequences for sexual violence



This illustration is adapted from Garcia-Mor
against women to reflect those health consequen

2.5.1 Sexual violence as a risk factor for sexually transmitted infections including HIV

There is evidence that sexual violence is a pathway for Sexually Transmitted Infections (STIs) including HIV[86-88]. There are additional interactions between HIV and violence that require further exploration. For example, HIV positive women are 2.68 times more likely to experience violence[89]. In North Carolina, USA, women who reported broader gender based violence were more likely to have sexually transmitted infections[90]. Childhood and adolescence violence has been associated with high sexual risk-taking behaviour. Abused women and men are also more likely to engage in behaviour such as drugs, alcohol and transactional sex that increases their risk of exposure[25,31,91].

STIs compromise the integrity of the mucosa thus increasing risk of HIV transmission. The prevalence of genital ulcer diseases (herpes, chancroid or syphilis) is associated with an increased relative risk of HIV infection[92]. In Uganda a study of 174 monogamous couples

showed that high viral loads and genital ulceration were the main determinants of HIV 1 transmission[93]. There have been documented instances of higher prevalence of STIs including chlamydia, gonorrhea, trichomonas and bacterial vaginosis, among survivors of sexual violence than in the general population. The presence of non-ulcerative or ulcerative sexually transmitted diseases facilitates transmission of, or increase susceptibility to HIV infection.

The likelihood of HIV transmission in the context of sexual violence is thought to be more than that of consensual exposures because of high levels of accompanying violence, increased risk of micro-trauma to vagina, genital injury which is common, anal rape and ejaculation during rape[94]. Additional factors include the type of exposure (body fluids and routes of exposure, integrity of mucosa and the number of discrete contacts) and multiple penetrations or perpetrators[95]. Anecdotal reports of HIV sero-conversion after sexual abuse have been documented[96,97].

2.5.2 Routine prevention/treatment of STIs (excluding HIV) is recommended

Treatment of sexually transmitted infections (excluding HIV) can result in increased trauma for survivors. Where survivors have to undergo STI screening through sample collection, the chances of psychological trauma are increased. Current practice for STI treatment includes the provision of a broad spectrum of drugs used for syndromic management. Given the constraints in follow up and concomitant health implications and risks for HIV infections, it is increasingly recommended that survivors of sexual violence are provided with these antibiotics in combination for empirical treatment and prevention as prophylaxis[83].

Few studies have described the utilisation of STI prophylaxis or demonstrated any impact for survivors of sexual violence. Guidelines on indications are not available, and recommendations made for routine provision are based on treatment guidelines post screening.

2.5.3 The rationale for HIV PEP following sexual violence

HIV/Post exposure prophylaxis (PEP) is a 28-day dose of anti-retrovirals given to HIV negative persons who may have been exposed to HIV. HIV/PEP should be initiated the soonest possible with 72 hours post-exposure[98]. Recommendations for using PEP for

accidental exposure by health providers are based on studies that demonstrated 79% - 81% reduction in the likelihood of HIV infection[99]. There are no randomised controlled trials directly supporting the use of non-occupational PEP after sexual (mucosal) exposures due to technical and ethical limitations of population sizes and randomising controlled trials. Several related sets of data from occupational exposures, Mother-To-Child-Transmission (MTCT) studies and animal studies support the biological plausibility. There however remain uncertainties regarding the validity of generalizing results of non-mucosal exposures to mucosal exposures, though risk for infection is similar [100-103]. Data demonstrates that people with sexual exposures will seek PEP and this may be linked to their perception of risk[104].

Varied justification has been presented for provision of HIV PEP routinely to all survivors of sexual violence in varied settings. Kim et.al (2004)[105] justify PEP use in high HIV prevalence settings, where concomitant STIs are common such as sub-Saharan Africa. Finding perpetrators and evaluating their 'risk profile' is challenging and there appears to be limited predictive value, and potentially high costs in HIV testing of vaginal washings, making their use prohibitive[106].

Common regimes used for PEP post sexual violence include a combination of anti-retroviral drugs, often two nucleoside analogue reverse transcriptase inhibitors and sometimes a protease inhibitor [98,107]. Often, the combination of Zidovudine (AZT/ZDV) and lamivudine (3TC) is used as it appears to be more tolerated than some other PEP regimens. There have been suggestions that the use of Tenofovir (TDF) based regimen may be more tolerated than the ZDV-3TC regime[108]. It has been suggested that twice daily regimens of PEP may improve compliance[96]. The addition of a third drug, often a protease inhibitor, increases side effects and potentially negatively influences PEP completion[109].

To date, only theoretical evidence exists to support the additional protective benefits of dual- and triple- therapy for PEP. PEP is not 100% effective and infections have been described following PEP for non-occupational exposures[110,111]. Where the HIV exposure source is known drug substitution is encouraged to overcome the effects of cross-resistance that have been documented amongst the Nucleoside Reverse Transcriptase Inhibitor (NRTI) class of ARVs[112] and thus enhance drug potency[113]. However, this is difficult in a context of sexual

violence, where the perpetrator is often unknown. Given PEP suppression of viral replication sero-conversion may take longer and thus follow up is required[114]. However, follow up of sexual assault survivors remains challenging in contexts where active location and follow up are not done[115,116].

Where PEP has been prescribed for sexual assault, reports indicate that acceptance of PEP medication, completion of regimens and follow up rates, remain poor[117]. Poor completion is reported from service delivery programmes and studies and more so those offering three drugs, particularly where a protease inhibitor is prescribed[108,118]. Literature on adherence is primarily based on broader anti-retroviral therapies (ART) for HIV positive persons. Factors associated with non-adherence to ART include side effects, forgetting, sickness, regimen complexity, duration of prescription and scepticism regarding the efficacy or value of medication, and limited information regarding treatment options and efficacy. Psychological distress in the form of depression, anxiety, self-blame and denial coping have been related to decreased adherence[119]. Subjective toxicity has been documented in people taking PEP and has been advanced as part of the reasons for lack of adherence/completion. In addition, financial constraints have been documented as reasons for lack of follow-up. Where starter packs of PEP have been given, return levels for longer-term medication are poor. It appears that majority of the studies with high PEP completion rates also have active follow up systems, or staggered dispensing of medication[120] and are primarily located in Europe and North America[108]. The capacity for counselling support and follow up infrastructure to monitor adherence and side effects is a significant challenge for developing countries[121].

Due to lack of efficacy studies, the optimal medication regimen in terms of drug types and combinations, length of prescription is unclear. There still exist questions regarding the baseline risk of sero-conversion after sexually violent exposures, how clients deal with their HIV status at such a traumatic time, and the impact of PEP on other post rape services[23,122,123]. Requirements for HIV testing, and additional baseline laboratory testing, present challenges in low income settings. Some authors suggest that the short regimen given for PEP in comparison to life long ART, does not warrant kidney and liver function tests and that it is most probable that any side effects are reversible[108,124]. Additional relative contraindications in PEP-prescription, such as whether or not to indicate PEP in isolated or chronic exposures,

remain[110].Risk reduction measures for sexually active persons and breast-feeding women are advised during PEP use[125].

Smith (2001) argues that despite the moral pressure to provide PEP for sexual violence, the potential benefits are currently unproven and that the potential risks and costs for PEP as population strategy may be much higher. However, it has been suggested that the benefits of PEP in certain high-risk instances of sexual violence outweigh its costs and risks, especially with regard to adolescents and children[96,126].

2.5.4 Sexual Violence as a risk factor for unwanted/unintended pregnancy

There are currently no data to demonstrate the risk of pregnancy resulting from sexual violence. It has however been reported as highly traumatic and often unwanted. Risks of morbidity and mortality from such pregnancies are higher, often due to use of unsafe (and usually illegal) abortion to terminate the pregnancy[25]. Routine provision of emergency contraception (EC) is recommended for all female survivors of sexual violence, and within the reproductive age group, and who report not being on a reliable form of contraception at the time[76]. EC has been described as 'providing just that extra margin of safety when addressing the consequences of sexual violence and rape'[127]

Emergency contraception prevents pregnancy after unprotected sexual intercourse. The two main oral regimes used for emergency contraception are progesterone only pills or combined (oestrogen and progesterone) pills. The latter also referred to as the Yuzpe regime has replaced progestron only containing pills to become the primary EC method due to its few side effects[128]. However, progesterone only pills are considered more efficacious. An additional method has been the insertion of a copper-T intra-uterine devise (IUD) post coitus. The failure rates of the various emergency contraceptive methods have been calculated at between 0.2% and 6%. Additional data shows about 74% efficacy of oral emergency contraception taken within 72 hours of exposure. The range of effectiveness of EC is largely due to imprecision in estimating expected pregnancies at the time to medication and loss to follow-up in many efficacy studies[129]. Factors that can potentially reduce the efficacy of EC include frequent use (though no definition of frequent is provided), vomiting that occurs within 3 hours following treatment and incomplete treatment[128,130]. Data suggests that the

prophylactic use of anti-nausea medicine can reduce incidence of vomiting, thus increasing efficacy of EC.

In countries where emergency contraception is offered, its availability and use vary widely and are influenced by regulatory policies, awareness of the treatment option, and provider and women's attitudes towards it and costs. There has been and still is lack of public awareness of EC, thus it is often not prescribed and women do not ask for it. The moral debates surrounding emergency contraception have influenced its acceptability, uptake and scaled up use in different countries. *First,* is what is considered the abortive effects on the foetus and has been framed in the context of 'murder'. This makes social acceptability especially in religious contexts challenging. *Second* is the use of emergency contraception for teenagers and in the context of pre-marital sex where sexual activity is sanctioned. Much of the literature on emergency contraception is concentrated in developed countries[127,129].

2.5.5 Sexual violence as a risk factor for a range of mental health consequences

Sexual violence is physical, emotional and moral and associated with the closest human intimacy of sexual contact. Sexual violence by its very nature produces psychological trauma. Emotional consequences expressed as part of a range of post traumatic stress disorders are often longer lasting and more difficult to diagnose and deal with[131]. Literature increasingly utilises the term sexual trauma to refer to distress resulting from experiencing sexual violations[132].

Research shows diversity in emotional outcomes of sexual violence ranging from mild and short - term to severe and long-term. This diversity in psychological outcomes may be attributed to varied characteristics of violent acts, survivor attributes or social support systems available[132]. These are often largely complex and unique to every individual. They include behaviour and personality changes that are manifested in a wide range of ways[133]. Manifestations may be physical such as pain, nausea, vomiting and headaches. Behavioural manifestations may include eating disorders, sleep disturbances, abuse of drugs and alcohol and changes in normal day-to-day functioning. Self-blame, guilt and humiliation are psychological influences that lower self-esteem. Sexual violence is reflected in the destruction of and individual's quality of life, diminishing productivity and eroded self-esteem and

worth, all of which impacts negatively individuals and families[131]. Clinical trials suggest life long emotional trauma that is often compounded by prejudice and stigma associated with rape[134]. Further, literature shows increased vulnerability to alcohol use, interpersonal problems, higher sexual risk behaviour and increased risks to future sexual violations.

Counselling is key for speeding the recovery process that is often individualised and may last many years [25,135-137]. A variety of models have been developed for counselling trauma and appear to focus on empathy induction aimed at restoring feelings of confidence and self worth[132,135,138,139]. However, Wasco (2003)[140] also makes problematic models that are used for trauma recovery and suggests that they are too narrow to capture complexities of women's experiences of sexual violence in a gendered society. S/he argues that some of the applications of trauma models may legitimate one socio cultural manifestation of distress over others. Further, re-victimisation of survivors is experienced in differing contexts by the survivors themselves and through experiences of societal and cultural responses to rape[141]. Thus, counselling requires taking into consideration existing contexts and gendered experiences.

Counselling following sexual violence is required to avert the outcomes of post traumatic stress disorder. In the context of high HIV prevalence settings, there are fears of HIV infection, and it may often be difficult for the survivor to judge the risks of HIV exposure and infection immediately following assault[142]. Thus counselling is required for HIV testing and should allow the survivor to provide informed consent for both HIV testing and for PEP initiation[143]. Counselling for HIV testing has been developed within a context of voluntary counselling and testing. It draws from humanistic theory that centres on the client with the assumption that persons can make the appropriate judgements for themselves with counselling guidance. It utilises cognitive-behavioural approaches that assume the ability of people to rationalise their actions and make behavioural changes regarding those actions that produce negative results. These counselling techniques support the client to explore and understand their HIV risks and then make changes in their behaviour[135,139,144-147].

Literature on HIV PEP delivery acknowledges the need for integrating counselling into the treatment programme, *"HIV PEP should be provided in the context of a comprehensive treatment*

and counselling programmes that recognizes the physical and psychosocial trauma experienced by victims of sexual assault" (pp323)[148]. The range of counselling required includes trauma prevention, HIV pre and post test counselling and PEP adherence counselling. This is attributed to the complexity of interactions between the side effects of PEP and those of trauma following rape[149]. In addition, adherence to PEP medication is poor (2.5.2.1). Counselling has been suggested and delivered to enhance completion of medication, thus optimizing on PEP[111,150].

2.6 Conceptualising sexual violence: micro/meso (household/community) level influences

Age of the survivor is increasingly identified as a risk factor for sexual violence[72]. Children's (both male and female) comparatively weak social standing, economic dependence and lack of political rights increase their vulnerability to sexual violence[9], with most perpetrators known to the children. Child rape, an increasing phenomenon in Africa has been associated with HIV/AIDS. Women report using more physical abuse on young children than men [24,151]. Literature on women as perpetrators of sexual violence is lacking.

The interface of household and community level characteristics that have been studied as risk factors for violence include: age at marriage, number of children and living in large or crowded homes. However, different studies revealed varying and sometimes conflicting results[152,153] and such differences are likely to relate to diverse study designs and cultural variations.

Gender power relations exercised in patriarchy often form the basis of norms regarding expected behaviour. Concepts of masculinity encourage multiple sexual partners and engagement in risky sexual practices as a manifestation of manhood. For example, Martin (1999)[154,154] found that Indian men who engaged in extra-marital sex were more than six (6) times more likely to abuse their wives than men who did not, hence increasing the vulnerability of their wives to both violence and HIV/AIDS. Gendered expectations are that women ensure functioning of their families at whatever the cost. Shame of divorce and separation, sense of failing, stigma and social seclusion are barriers to women reporting violence. In addition, fear of retribution and economic dependence on perpetrators negatively

influences women's decision-making about abusive relations, for themselves and their children's relationships[29,155-157].

Social rules and regulations are often based on gendered perceptions[147]. Where these 'rules' are transgressed stigma may result. Stigma has been re-conceptualised in the context of power, as socially constructed and reproduced[147]. This is in contrast to the widespread understanding that it is an un-desirable attribute mapped on to people who are in turn negatively valued, thus assuming some sort of stasis. Stigma and discrimination therefore are power tools used to legitimise social inequalities based on differential understandings of value and worth. For instance, women involved in sex work are at increased vulnerability to sexual violence given the existence of cartels and police that control their trade. These understandings are grounded in social and gendered constructions[147]. In the context of sexual violence and the social construction of stigma, survivors, who are primarily women are often blamed and punished[158].

2.7 Conceptualising sexual violence: meso/macro (institutional) factors of influence

Much of the literature on meso/macro level factors that is explored in this thesis is based on the health sector, while acknowledging that other macro level influences in the prevention, care and rehabilitation continuum are intimately connected to the health sector. In the following subsection, I examine the health requirements for including clinical evaluation and legal documentation. The purpose is both to assess and provide health care, and at the same time collect and preserve evidence for the justice sector. Thereafter, I focus on the health sector institutional responses.

2.7.1 Clinical evaluation and legal documentation are essential

The WHO detailed 'guidelines on the medico-legal care of victims of sexual violence' summarise assessment and examination procedures, as drawn from varied international experience and literature[159-161]. This includes physical examination that is thorough, undertaken with informed consent by the survivor, in an empathetic manner with all necessary information provided and done simultaneously with collection of forensic evidence

to minimise survivor intrusion and trauma. Key steps to assessment and examination include[76].

- Initial assessment of the survivor including triaging, determining extent of injury
- Taking a history including medical and obstetric/gynaecological history, occurrence of assault
- General medical examination including in which a thorough external and internal examination that cover the 'head-to-toe' of the client is done. The genital-anal examination should be undertaken using a speculum and the comfort of the survivor takes priority.
- Appropriate labelling of all specimens collected, and official handover of specimens and evidence.
- Recording and classification of all findings from the assessment requires attention to detail as these form part of the legal evidence often used in court.
- Forensic specimen collection often depends on the technology available for analysis. Minimum standards are provided on specimen handling and analysis and requirements.

2.7.2 The health sector is gender blind

Gender approaches to health are broadly concerned with the ways in which gender relations influence disadvantage within the health care systems[16] as well as how the gendered nature of health sectors/models responds to women's needs[162]. Gender mainstreaming in health requires that *"preventive and public health (and curative) interventions are placed within social contexts of occurrence and recognise and respond to the needs and priorities of women, girls, men and boys"*(p143)[163]. The health sector has a special interest in addressing and preventing sexual violence. Immediate and short-term effects and health outcomes of sexual violence have implications for curative (bio-medical) services and for public health. A biomedical approach focuses on causation of ill-health by specific external agents, subscribes to a generic and universal view of ill-health and uses pharmacological tools for prevention and curative purposes. This is the predominant approach by many government and international agencies to health systems and services[162].

Biomedicine is a highly gendered discipline and the way in which medical knowledge and systems are organized often reproduces inequalities and hierarchies in many dimensions of

health systems, policies and services. Social, economic and political factors that influence ill-health are not recognized in this context[54,162,162]. The multi-dimensional and intersecting factors at individual, social and institutional levels that influence sexual violence are ignored during care with an exclusive focus on technical content of treatment[22,164].

Public health approaches on the other hand are concerned with the health of communities and populations with an emphasis on injury (and disease) prevention.

> *"A public health approach focuses on prevention and emphasizes opportunities for early interventions. It is based on sound research includes a social analysis of health, and has an interdisciplinary approach...Prevention strategies need to be context specific and address particular risk (and vulnerability) factors that are relevant to each setting"(134-5)* [22].

Multi-disciplinary working and the use of a wide range of professional expertise from other fields[24] to provide care within the prevention, care and rehabilitation for sexual violence are essential. They are however, constrained by fragmentation of health sector responses into special areas of interest and expertise where the wider connections such as those of sexual violence are unattended. For instance, despite the pervasiveness of violence, it is not an integral part of professional health service provider training and where undertaken, it often does not address gendered experiences, attitudes and values of service providers[22,29].

Increasing attention to a gender and health equity analysis in public health approaches insists on the need to distinguish between biological and social factors. Interrogating gender risks, vulnerability and resilience facilitates changes in conceptual approaches, questions and methods in research, policy and delivery of health care[165]. Theobald et al (2005)[166] note the challenges of developing understanding of gender analysis and planning throughout the health sector. Questions emerge on what concepts and 'strategic frames' are most likely to have impact in advancing gender equity in the health sector.

2.8 Considerations for policy and programming responses for sexual violence

This section also draws on the meso/macro levels of the VHA framework, applying it to health sector responses. I focus on existing programming responses in the broader health

sector in resource-limited settings in particular, sub-Saharan Africa. It provides a background to the context in which recommendations for interventions found in the literature would be made operational. It also contextualises the policy and practice environment in which this study was undertaken. I also explore issues, concerns and challenges for post rape care delivery in the broader health sector highlighting key considerations for practice.

2.8.1 Health sector reforms in resource-limited settings

Health services delivery in most of sub-Saharan Africa has been subject to health sector reforms since the 1980s. These have included fundamental changes in national health policy and institutional arrangements guided by government. They aim to ultimately improve the health status of the population. Health sector reforms were precipitated by poor health sector performance and functioning that was attributed to various contextual factors that have been described as "inter-related and mutually reinforcing", including political/policy/ideological factors, economic factors, health epidemiology and new disease concerns and health systems issues (access, quality, efficiencies, community participation, poverty, programming [vertical or horizontal], coordination, drugs and supplies, health worker capacities and the systems responses to consumers)[167-169].

The main reform agenda items have related to:

- Stewardship of health systems - policy formulation, strategies, inter-sectoral collaboration, coordination and decentralisation
- Organisation and management of health services - integration of services, community participation, essential health services packages, strengthening institutional capacity
- Provision of quality health care - human resources, availability of essential drugs, improvement of quality services and operations/essential research
- Financing of health services - increased budgetary allocation, broadening resource bases and improved management of resources

Achievements are reportedly greatest, in amongst other areas, in decentralisation, development of national health policy or sector strategy, development of essential drugs lists, improving the financial resources for quality health services[168]. Literature highlights gender inequalities in health care at both demand (delivery) and supply (access, uptake and

utilisation) levels. However, health sector reforms in their focus on both efficiency and devolution of power, appear to ignore the question of gender in terms of data analysis, planning and definition of outcomes[170]. Thus, health sector reform processes that have defined health care systems in sub-Saharan Africa appear to have largely ignored gender concerns including: attention to women specific health needs that form a considerable part of health care, equitable distribution of power in decision making structures and gender differential health care access barriers (such as the impact of user fees introduced as part of decentralisation processes)[15,171,172]. Health sector reforms are increasingly undertaken in resource poor settings within the framework of Sector Wide Approaches (SWAps)[173,174]. SWAps aim to consolidate budgetary support to formulate, implement, report against and evaluate a coherent single sector policy. The logic of SWAps theory is that this could build strong national capacity to implement sustainable, nationally owned responses. Donor agencies thus channel support to government set priorities, common execution and monitoring arrangements, creation of linkages between health plans and budgetary systems, and place emphasis on institutional strengthening[174,175]..

Challenges to the implementation of SWAps have included fragmented and project oriented assistance, donor driven health priorities and lack of broad-based sectoral policies and practices. Cassels (1997)[174] points out the contradictions of SWAps within decentralised systems, such as that adopted in Kenya (section 3.8). Within decentralised approaches, local government or district health systems ideally have control over budgetary resources. They embrace the micro-level decisions about priorities and efficiencies at the local levels. Conversely, SWAps are centrally planned and concerned with allocation decisions made at the national level. They thus appear to reinforce top-down planning with little or no emphasis on bottom-up approaches aimed at feeding district and local plans into national planning[173]. SWAps also appear to have created ambiguities between the centre and the districts as communication linkages, feedback mechanisms and lines of accountability and responsiveness to local level realities remain unclear[168,176].

2.8.2 Vertical and integrated health services delivery in resource-limited settings

Health care services in sub-Saharan Africa are delivered through two broad approaches. Horizontal/integrated programmes are holistic, centre on local needs and deliver a wide

range of services. They are long-term and strengthen health infrastructure and create systems of permanent institutions[177,178]. Integration has increasingly expanded from bio-medical services to focus on broader public health domains, thus employing multi-sectoral strategies, programmes and activities. Choosing between cost effectiveness and equity in a context of meagre resources has meant that horizontal programmes are spread-thin and develop limited capacity and poor infrastructure[179,180].

Vertical programmes have single-purpose machinery (facilities, human resources, management, information, logistics and supplies) and have been successful for the control of specific priority health problems [178]. They however are seen to divert time and attention away from other priority areas in the broader health system. Being supported and effectively run from the centre, vertical programmes face challenges of local level management and coordination for inter-sectoral planning and functioning, community involvement and inter-agency dialogue. Specialist training, infrastructural support and direct relationship with the centre for specific health services and providers is problematic for shared goals and aspirations and local ownership in the health sector. Beneficial effects include training for select health providers that boosts motivation and better targeting of resources. However, the programmes are *"...organizationally separate from the mainstream health care delivery structure, they add to the strains on public health care by drawing on the important scarce resources of trained personnel"*(p379)[181].

While presented as distinct, there are many overlaps that suggest complementarity of these approaches. Within both vertical and horizontal programmes are factors influencing the extent to which integration of any health programme is feasible. These include the type and complexity of technical skills necessary in relation to the skill available, support required and strategies for acquiring it, acceptance of service by health workers and communities, the data necessary for evaluation and means of collecting it and the extent of provision of basic health services[179]. Relative effectiveness of services and efficiency gains in the health system are determined by characteristics such as staff training, supervision support, staff morale and opportunity costs of interventions[178]. Arguments exist for implementation programmes to recognize that they built onto and work within existing infrastructure, knowledge and institutional cultures[182].

Within this context are increasing HIV/AIDS interventions that are largely vertical and are also responsible for PEP availability[183,184]. Theoretical links between HIV/AIDS programmes and other services have been identified. For instance, Askew(2003)[185] draws links between reproductive health services and HIV/AIDS services in care and management of sexually transmitted infections, family planning services including contraception, and counselling. Watts[186] draws links between reproductive health and post rape care. The authors note that in practice these links are often weak or non existent as experienced in Kenya (section 3.10). The need for donors providing HIV/AIDS funding to move towards building broader and necessary health sector capacities has been identified. Streefland (2005)[187] justifies this with the rationale that it is only with strong basic health services and clear linkages that long-term delivery of HIV care including anti-retroviral therapy can be accomplished.

2.8.3 Models for post rape care services delivery in resource limited settings

Models for providing care for sexual violence survivors in the health sector are largely from developed countries. One-stop facilities where survivors access all required services from one location are most common. All health services are offered in a designated location at the health facility. In these settings police are often called into the health facility to take statements and public attorneys and legal services provided. Where possible there are links with rehabilitation that ensure safety for survivors. Services are provided in the emergency department or in the gynaecological sections of hospitals[124,188,189].

In resource limited settings post rape care services (where available) are provided in a context of competing resources, poor infrastructure, low staff morale, rudimentary training, lack of procedures and protocols and in-availability of confidential spaces for treatment [180,190]. Post rape care services require linkages between services that are often delivered through varied units and programmes in the health sector. These include laboratory services, HIV PEP managed through vertical HIV/anti-retroviral therapy (ART) programmes, STI prevention and emergency contraception often managed through reproductive health/family planning services, and counselling services usually managed through mental health services. In addition is the need for investment in infrastructural, technical and human capacities of the health sector in a manner that is anchored on evidence bases[4,22,23,23,83,191].

Building evidence in resource poor settings is however constrained. *First,* the problematic nature of ensuring research utilisation has given way to increasing engagement of policy makers in formulating questions, conducting and disseminating research[192,193]. This is acknowledged as key for acceptability and effective utilisation of findings[194]. However engagement of policy makers in the study process faces academic and disciplinary challenges where differences exist between what is considered research and what is policy making, that has been described as a political process based on subjective interpretation of information[195]. *Second,* translating both research and policy into practice is challenged by complexities and context-specific nature of interventions, variability of methods, problems in generalising study findings across health settings and cultural diversities.

The need for evidence-based, context-specific interventions in providing post rape care has been identified. Avenues and opportunities for creation of linkages between public health approaches, clinical evaluation and management, and counselling are identified as necessary at health facility level for diverse reasons that aim to shape a holistic response[186,196]. Roland et al (2001)[197] observe that, *"establishing comprehensive post-exposure prevention programmes that incorporate risk reduction counselling with medication may facilitate integration of clinical and prevention services that traditionally have been separated"*(p1611).

Garcia-Moreno (2002)[22] notes

> *"Intervention research is also urgently needed to identify what works and what doesn't in different settings, in particular what is effective, sustainable and feasible in resource-poor settings. Models come mostly from the developed world... there is little or no evidence on which to make recommendations. It is necessary to assess critically evidence for the effectiveness of proposed interventions and to consider their appropriateness and sustainability in different settings, rather than making broad global recommendations"(p137)*

2.9 Theoretical foundations of the methodology used in this study

Qualitative research focuses on processes and meanings that are not experimentally measured. There is no one single line of thought on epistemology and methodology of qualitative research. Instead, it operates within complex historical contexts, with varied

practices, techniques of representation and interpretive perspectives[198]. Emphasis is laid on *"the socially constructed nature of reality, the intimate nature of relationship between the researcher and what is studied and the situational constraints that shape inquiry"* (pp:13)[5]. Quantitative approaches on the other hand encompass positivist paradigms that work within a realist epistemology and objectivity. They rely on experimental and rigorously defined methodologies that are deductive[199]. Both qualitative and quantitative methods can be used within a single study for complementarity. Qualitative research, and particularly feminist epistemologies require that the researcher should locate themselves in the process and its social and institutional locales, aware of hegemonic ideology when selecting approach, methods and techniques[200]. In this thesis, qualitative methods facilitated understanding of the meanings of sexual violence through establishing perceptions and social constructions of sexual violence in Kenya. This informed the development of an intervention that was process based. Use of quantitative measures was possible due to the flexibility offered by qualitative methodologies.

2.9.1 Feminist epistemologies

Feminist research broadly entails the focus on women's lives and experiences and gendered constructions of power and issues of reflexivity and representation[54,201,201]. The focus on women's lives and experiences in feminist research provides space for transformative action[201,201-203]. Feminist episetemologies requires research that undertakes gender analysis and helps to address the power relations underlying inequalities at social and structural levels. Theobald et.al (2005)[204] note as a challenge the task of developing an understanding of gender analysis and planning throughout the health sector, beyond policy statements to practical application. Feminist epistemologies further challenge the production and therefore the effects of knowledge. Haraway (1993)[205] sees knowledge as emergent from situated experiences, with information from individuals in the varied groups of participants being spatiallylocated , and therefore knowledge produced shaped by researcher's understanding. Hence, participant and researcher identities and interactions are continuously changing through a communicative process[206]. Researcher involvement is therefore 'constitutive' and power relations are constantly negotiated and redefined.

Reflexivity and representation attempt to address these power relations and have been made problematic. Gillian (1997)[134] notes *"there are real dangers that are inherent in our position within the powerful institutions of knowledge production"*(pp307). Position here includes institutional privilege, status informed by participant views (of the researcher being the 'knower') that interact with existing structural subordination and domination in society. However, Kincheloe (2003)[200] argue that the perceived power differentials may be a creation and perception of researchers to reproduce and imprint power. They instead opt for an analysis that bears in mind the tensions that exist in the contextual meanings of gender, class, age and the realisation of varied agendas within the research process[134,200,207]. The 'triple representational problem' has been identified[207] and is concerned with representation, voice and text of: the self as research planners, information collectors and interpreters; the interviewees (called 'narrators' by Fine)[207] and; the 'others' as the marginalised persons in any community. Representation, voice and text are areas of power for the researcher who has final power of interpretation[134]. All voices require critical analysis within the hegemonic and interpretive context in which they were collected and they appear. The dilemma is thus in ensuring representation that captures lived experiences, is less partial and is historically framed[54,208].

2.9.2 Drawing on action research principles

Various authors have provided descriptions of action research that encompass two key aspects:

- Pragmatist underpinnings: theory to praxis
- Co-generative inquiry and participation: new meanings are constructed through dialogue and participatory decision-making in questions and methods applied informed by both researcher and participant standpoints[5,209]. Collaboration in knowledge production and testing of results allows for social change.

Theoretical inquiry is transformed into praxis directed towards solving problems in given contexts [210] [209,210]. In using a pragmatist philosophy, the core reflection process is connected to action outcomes. Knowledge generation through action and experimentation in context is both a method and goal. WHO ethical guidelines for research on domestic violence[211] highlight the need for researchers, funders and research results to be utilised for social change

as a principle of beneficence[212]. Lofman (2004)[213] identify action research as a methodological continuum in experimental, organisational, professional and empowering approaches. Multiple research methods are used to understand the situation and challenges, document and critically assess practice, process and procedures directed by action[210]. *"All research therefore needs to be centred on those aspects of clinical enquiry that will impact significantly on daily practice, is practice based, rather than theory driven, concerned with improving patient care...Action research is one way theory may be generated from the practice setting"*(P5)[209].

The premise for co-generative inquiry is the creation of synergy of researcher professional knowledge and experience and participant in-depth understanding of local contexts. This potentially provides a comprehensive understanding of complex social settings and a flexible and interactive process that allows discovery and adaptation to unforeseen and unexpected events. Inherently, there is a commitment to view events, actions norms and values from the participant perspective. Collaborative co-generation of knowledge allows self-determining attainment of social change by participants, that aim for equity and emancipation, both goals for health interventions[209,210]. The concept of participation in action research is problematic in its aims, extent and implications, ranging from nominal, where the researcher is legitimised and the participant may access some benefits, to transformative where empowerment is the mutual aim. Therefore participation needs to be analysed holistically including the dynamics and influences on the whole study[210,213]. The conceptual clarity about the aims of participation, who by and when are guided by clarity on what is realistic, the organisation's mandate, local (institutional) politics, time and resources available.

2.9.3 Assessing performance of health service interventions

Evidence based practice is a requirement for health interventions and includes gathering information and its critical interpretation. Qualitative techniques have been utilised to describe and assess the functionality and utility of systems through indicators such as acceptability. Acceptability includes a focus on both health providers and health service recipients, and seeks to assess their perceptions and responsiveness to the intervention[214]. For example, Puentes-Markides (1992)[215] frames acceptability in the context of behaviour of health professionals and of clients. Considerations in determining health provider acceptability

include feelings, beliefs and biases towards women and men, awareness of disparities in health services and position on sensitive health issues such as reproductive health[216].

Quantitative techniques and data when pertinent, adds utility to and 'instrumental value' to information. It enhances understanding of processes and systems. Indicators to capture the success of intervention are located both within the health structure as well as outside. For instance, ability to pay for services impacts on access and equity outcomes, but is captured by indicators such as household income, which lie outside health sector planning and health care delivery systems[215,217]. Indicators have also been categorised as belonging to health sector structure, process and outcomes. However, Berg (2005)[218] sees an overlap between the classic distinctions of indicators, noting that they are proxies for outcome measures with blurred boundaries. For instance, what indicator would be appropriate to measure 'quality of service delivered by a clinician' - process or outcome? In addition, quality measures can be described by varied sets of indicators depending on what is being assessed. In the classic sense of evaluation of health interventions, a range of indicators and measurements have been used[219,215,218,220-222,223,224,225]. However, many of these require baseline indicators against which to measure the performance of the health service.

2.9.4 Methodological concerns in sexual violence research

There is growing literature on gender, HIV/AIDS, sexual violence and VCT (2.5, 2.6) However, there are only two studies that encompass all four thematic areas[226,89]. Both publications note the limited availability of data on specific pathways and intersections between violence and increased risk for HIV. In developing countries, increasing literature on sexual violence and HIV/PEP is largely bio-medical and concerned with working of HIV/PEP in particular[124,227-232]. Broad sets of literature on the psychological consequences of sexual violence also exist. There are also population based studies that are epidemiological in nature[233-236]. Few health facility based studies that are concerned with provision of services for sexual violence exist in Africa, and these are largely based on quantitative methodologies[237,238]. In his review of literature on sexual violence, Randal (1997)[35] points out that epidemiological data on sexual violence is sparse and that therefore there is limited evidence for evaluating interventions on sexual violence.

Various methodological challenges have emerged with these studies, that may explained by the diverse disciplinary orientations that have shared interests in understanding sexual violence[186]:

- The lack of a clear definition of concepts such as rape, gender based violence, HIV risk etc which compounds the difficulty of comparing incidence and prevalence of violence[239]
- The lack of a standard method of measurement of violence and timeframes against which to measure violence (in the last 1 year, in your lifetime etc)[240]
- Challenges in measuring chronicity (frequency/duration) for some forms of violence such as marital rape[241]
- Methodological and conceptual differences of researchers in their use of tools and sampling procedures[12]

While Jewkes critiques qualitative methods for their inability to measure issues such as prevalence and strengths of associations between various parameters, she also notes their strengths in supporting the development of theoretical frameworks for understanding and measuring sexual violence. Jewkes (2002)[242] and Randal (1997)[35] both note as an emerging concern the limited attention given to using qualitative methods in research on sexual violence. Understanding and measuring sexual violence with quantitative approaches is challenged by its very nature which is centrally located in the social sphere and thus requires a deep understanding of people's views and contexts.

2.9.5 Ethical issues in sexual violence research

Research in sexual violence involves inherent risks of safety and may risk lives of respondents and interviewers. The WHO (1999)[211] have published guidelines for addressing ethical and safely issues in domestic violence research. Non-maleficence requires awareness of the intrusive nature of research and the potential for participant distress in discussing painful and frightening experiences despite its cathartic advantages. In addition, are risks of further violence to the survivor and the researcher from the perpetrators or communities especially where sexual violence is accepted. Ellsberg (2002)[212] notes the need for interviewers to be trained to be aware of their own attitudes around sexual violence, of the effects their questions and on how best to respond based on women's distress levels. As a minimum standard, researchers have an ethical obligation to provide participants with information on services

that can respond to their situations. Beneficence ensures that research results build upon knowledge and action in advocacy, policymaking and intervention. Tools and methods should capture positive emphasis of the situation and results feedback should be given to participants[211,212].

Consent is problematic. While participation is voluntary and non-conditional, the right to withdraw is seldom used. Molyneux (2004)[243] demonstrates a range of inter-related issues including expectations of participants, perceptions of benefits accrued from participation as being impacted on by consent. Clear communication of the risks, benefits and purpose of the research allow the participant to understand and make an informed choice on participation. This is however challenged by conceptual and linguistic barriers, as well as motivations of both the research communicator and client[243].

Where health providers are research collaborators, the dynamics in provider/client relationships are inherently introduced into the study process. They may imply 'forced' cooperation in the research process. These dynamics have been highlighted in action research studies where hospital management are accepting of the study and some health staff are not[213]. Fine (2003)[207] adds concerns about the object of informed consent exercises. While it is presented as protecting the participant, she contends that informed consent procedures protect the researcher and release institutions from liability for harm while giving control of the research process to the researcher. *"The informed consent sits at the contradictory base of the institutionalisation of research..." reflecting on my experiences with the form revealed the complexity of both my role as researcher/activist and the constraints of developing collaboration between subjects in a context of real power imbalances" (pp177)*

2.10 The relevance of these literatures

The first set of writings conceptualised sexual violence as it is understood and utilised in this thesis. Given the health sector location of this study, and the focus on influence of policy and practice, the WHO frameworks provided a suitable basis for this conceptualisation.

Feminist perspectives provided a background against which to understand the social location as well as theorize sexual violence. In addition, literature on feminist and women's movements provided a basis for understanding the trajectory of sexual violence in Kenya (3.5). Findings and discussions in chapter 5 that focused on the social location of sexual violence drew on these literature. I acknowledge that sexual violence against men requires inquiry when responding to sexual violence. However, this remains a gap in this thesis, mainly because the conceptualisation of sexual violence in the feminist discourse, which informed the Kenyan public discourse, is largely absent.

The third set of literatures utilised the VHA categories to explore and analyse the health sector influences and outcomes. The biological factors (2.5) were fundamental in shaping the intervention design as a key function of this thesis (chapter 8 and 9). Literature on the community related factors influencing sexual violence informed the design of uptake, delivery and acceptability indicators (4.5) and findings (chapter 8), the readings of findings in chapter 5, the design of provider training programmes and counselling protocols (chapter 7).

Literature on methodologies for qualitative research and more specifically sexual violence research provided a basis on which to develop the study design, sampling and data collection methods, and analysis (4.2 - 4.5). The ethical considerations in sexual violence research were taken into consideration designing the study methodology (4.7).

Literature that set the context of health policy and programming (2.8) provided a theoretical basis for understanding the context within which this study was undertaken. This understanding informed the study design, the intervention processes (chapter 7), and the assessment of the intervention (chapter 8). Understanding this practical and policy environment of services delivery also allowed for the process of policy reform advocacy (chapter 9) and the discussions and recommendations made in chapter 10 of this thesis.

There were gaps in literature. Feminist theorising on sexual violence is largely western located. There seems to be limited peer reviewed African literature on sexual violence, *re*, conceptualisations, forms and expressions, and responses. Thus, the extent to which the 'traditional/modern' tensions and evolving power and social structures that I suggested

(2.4.3) influence how sexual violence is conceptualised, experienced and responded to, remain unclear. Research is required to explore the gendered dynamics of sexual violence in the context of multi-racial feminisms and diverse women's movements in Africa and Kenya. This knowledge would open spaces to shape African feminism for targeted responses to relevant gendered oppression and diverse cultural subtleties.

A growing body of work links gender, violence and HIV/AIDS (2.6). However, analyses that locate institutional responses and bio-medical outcomes of sexual violence and HIV in gendered frameworks are limited. Discussions on the gendered nature of policy and practice seem to be based on theoretical gender analysis with varying experiences of 'policy evaporation' (2.4.1). There is an absence of data driven information on the ways in which gender issues at client, health care provider, prosecutor and magistrate levels influence delivery of services. Literature that explicitly attempts to analyse the ways in which gender relations shape delivery and up-take of health care services in the prevention, care and rehabilitation continuum is lacking. For example, the potential influence of gender relations on compliance/adherence to PEP remains unexplored.

Literature on models for the development of post rape care services are based in developed countries with high resources and low HIV prevalence rates and thus are not entirely applicable in low resourced settings (2.8.4). Thus, some of the methodologies employed in the development of service algorithms in this study were a deviation from existing models and the rationales are provided in chapter 7.

Different papers and reports (reviewed and grey literature) appear to focus on the different aspects of post rape care; post traumatic stress, HIV PEP, forensic examination/treatment characteristics, pregnancy and STIs. There appears to be no reviewed papers from the databases searched that provide data on post rape care, with the exception of one paper on pilot referral centre in London[244]. For instance, uptake and outcomes of emergency contraception in the context of sexual violence, given the ethical debates is under-researched.

Little is known about HIV PEP in non-occupational settings. Adherence for HIV PEP in complex emotional circumstances, such as experienced in the context of rape remains unclear.

This is further complicated by lack of efficacy data on use of PEP for non-occupational exposure and lack of literature on appropriate emotional support in the context of sexual violence in high HIV prevalence settings. Counselling literature (information and skills) for post traumatic stress disorder in the context of sexual violence does not cover HIV test counselling. ART adherence counselling information does not provide guidance on HIV PEP adherence counselling in the context of sexual violence.

Chapter 3 A background to this study

3.1 Introduction

A background of Kenya and the study context are provided in this chapter. Section 3.2 highlights the history, administration and economy of Kenya. Published and grey literature on the pervasive nature of sexual violence (limited as it is), and HIV/AIDS is outlined next (3.3). Section 3.4 maps out the trajectory of sexual violence in Kenya highlighting feminism and the women's movements as they emerged, their internal tensions and challenges and their role in shaping the sexual violence debate in Kenya. Community related factors of influence are outlined in section 3.5. Institutional level factors are discussed in two broad categories, legislative and justice sector responses (3.6) and the health sector (3.7) as the policy and institutional framework. Health sector challenges in delivering post rape care (3.8) are outlined. Liverpool VCT and Care (LVCT) Kenya, as the host organization for this study is described and its location within this study identified (3.9). Section 3.10 introduces and provides a background for the study districts and health facilities. In section 3.11, I contextualise the rights discourse in Kenya by drawing on the relevance of the sexual violence and women's movement to the uptake and delivery of post rape care services.

3.2 Kenya has a diverse population and 3 parallel governance systems

Kenya is divided into 8 provinces and 105 districts, with the district as the smallest unit of planning. There are approximately 42 ethnic groups distributed across the country and the provincial boundaries appear to group various 'related' ethnicities together. The official language is English and the national language is Kiswahili. Main religions are Christianity and Islam. In 2003, the Central Bureau of Statistics projected the population of Kenya to be 32.2 of whom approximately 52% were women. This was based on results of the 1999 national census and an annual population growth rate of 2.9% per annum. According to the 2003 Kenya Demographic Health Survey, the fertility rate is 2.9 and the infant mortality rate is 77.3 per 1,000 live births and life expectancy at birth has fallen from 60 to about 55 years between 1989 and 1999. This has been attributed to the impact of HIV/AIDS, deterioration of

health services and widespread poverty. The proportion of the population in the rural areas is higher than that of urban areas.

Three parallel governmental structures are in place for governance, policy implementation and services delivery at district levels. These include the sector/central systems (such as the Ministry of Health), the local government (governing the district level), and the administrative system (commonly referred to as provincial administration) run from the Office of the President (annex 1). These parallel systems present challenges for accountability and management of service delivery and reporting, at national and district levels. Women's representation within all three government systems is dismal, perhaps influenced by the structural complexities, particularly at the higher levels of decision-making[245,246]. Attention to gender concerns is increasingly seen in these national strategies and programmes. However, in how far these policy commitments translate to action has been questioned. Gender tends to undergo 'policy evaporation'[59].

3.3 Sexual violence in Kenya

No nationally representative data on sexual violence existed until the 2003 Kenya Demographic and Health Survey[247] . This survey shows that 43% of women aged 15-49 years reported having experienced some form of gender-based violence in their lifetime with 29% reporting an experience in the year preceding the survey, and the highest proportion is among women aged 20–29 years. More specifically, 16% of women in this age group reported that they had ever been sexually abused, and for 13% of them, this had happened in the last year[247]. The Government has cited sexual violence as an issue of concern in various policy and strategic documents in Kenya: the National Population Advocacy and IEC strategy for Sustainable Development 1996 - 2010[248], the Mainstreaming Gender into the Kenya National HIV/AIDS strategic plan 2000 - 2005[249], The Kenya National HIV/AIDS Strategic Plan II (KNASPII) 2005 - 2010[250].

Published literature reporting gender based, and particularly sexual, violence in Kenya is limited. A survey of domestic violence in Kenya by the Federation of Kenya Women Lawyers[251] showed that 51% of women visiting four antenatal clinics in Nairobi reported

having been victims of violence at some point in their lives, 65% from their husbands and 22% from strangers. In a study of 324 HIV positive women in Kenya, 19% had experienced violence from their partner[186]. At a 'consensus building' meeting on mainstreaming gender into the Kenya national HIV/AIDS strategic plan on November 8th 2002, discussions clearly pointed to growing evidence and concern of HIV infection due to gender based violence in homes, schools, workplaces and other social spheres in Kenya.

Adolescent sexual activity is often assumed to be consensual. However, evidence in Kenya suggests otherwise. A study of 10,000 female secondary school pupils in 1993 found that 24% of the sexually active girls reported experiencing forced sex on their first encounter[252]. In a study on contraceptive use among high school students, 9% reported not using a method at last intercourse because they had been forced to have sex[253]. A countrywide study showed that pressure starts at an early age, with 29 per cent of girls and 20 per cent of boys aged 13 years and below reporting one or more episodes of sexual harassment[254]. The vulnerability of young women is increased by the likelihood of coercion into sex and rape, often by someone older, who has had exposure to HIV[255].

3.3.1 Sexual violence and HIV

HIV/AIDS spread rapidly in Kenya during the 1990's reaching prevalence rates of 20-30% in some areas of the country. National prevalence is 7% in 2003[247]. Two thirds of those infected are women and about 100,000 children living with HIV. The gender difference is most pronounced among young people, in the 15-24 age range, female prevalence is nearly five times higher than male prevalence (5.7% and 1.2% respectively). It is this age range that is also vulnerable to coerced and forced sex[29,35,40,41]. The age of sexual debut in Kenya is 17 years for girls and 16 for boys. Studies highlight continued high-risk sexual practice despite high rates of adolescent pregnancy (23%) and abortion. 50% of new HIV infections in Kenya occur among adolescents (10 - 24 years)[247]. The response to HIV/AIDS in Kenya is based on a Government Sessional Paper (No. 4 in September 1997) that provided "a policy framework within which AIDS prevention and control efforts will be undertaken for the next 15 years and beyond".

Government documents also acknowledge sexual violence as a concern amongst adolescents. There is *"growing evidence that a large share of new cases of HIV infection is due to gender-based violence in homes, schools, the workplace and other social spheres. Not all young people have sex because they want to. In a nationwide study of women 12 – 24 years old, 25% said they lost their virginity because they had been forced. A recent Nairobi study indicated that 4% of HIV infections in the adolescent 13 – 19 year age group were a consequence of rape"*(p2)[249]. Additional reports from non-peer reviewed material by the Kenyan police, the media and various non-governmental organizations show increasing public reporting of sexual violence. Children are more vulnerable to sexual violence. It is estimated that 1.7 million children under 18 are orphans, about half due to AIDS[247]. According to Amnesty International (2000)[256] in Kenya, *"there is a reported pattern of abuse by men who target minors for sex in the belief that they are less likely to be infected with the HIV/AIDS virus. Men infected with HIV/AIDS have reportedly raped young girls under the illusion that they will be 'cleansed' by having sex with a virgin"*(p9). The vulnerability of orphaned children (both female and male) to sexual violence increases due to the lack of parental support and protection and as they drop out of school to fend for themselves. Parental presence in the household has been shown to be protective against a range or risky sexual behaviour[257]. Community structures for caring for orphans have been over-stretched and cannot adequately care for and protect orphans[29,89,249,254].

3.3.2 Gaps in Kenyan literature on sexual violence

Children: Kenyan studies on sexual violence amongst children (magnitude, forms and expressions, responses) are lacking despite the increasing media reports and anecdotal information from reports.

Men: Data on sexual violence against men became increasingly available during the life of this study. Homosexuality is criminalised in Kenya under the penal code in the constitution (Chapter 63, Section 162). Njue et al (2005)[258] report 17% boys between 10 and 19years being involved in non-consensual sex, forced by girls/women who are often much older. They also make associations between the likelihood of males who have experienced forced and coerced sex, to become perpetrators of sexual violence at some point. In a study in Central Kenya of an evenly gender represented population of 1,783, 11% males and 21% females reported coerced or forced sex[254]. In this thesis, I did not place emphasis on male survivors from the onset as much of this literature has emerged during the life of this project.

Costs of sexual violence response programmes: Kenya lacks literature on costs of sexual violence and cost effectiveness of any interventions - behavioural, social, legal, health care or rehabilitative. There are no available studies either published in peer-reviewed journals or as grey literature in Kenya on costs of sexual violence.

3.4 Mapping the trajectory of sexual violence in Kenya

While this thesis focuses on and seeks to highlight influences on health facility post rape services delivery, it is worth noting that until 2003, the debates on sexual violence had been outside of the health sector, mainly within the feminist and women's movements in Kenya.

In order to trace the trajectory I sourced information from a variety of sources. In the following section, I map out this trajectory based on informal interviews with various rights activists (detailed in table 3.1 below) who have been involved at various stages in the women's movements in Kenya. These persons were selected through a snow-balling process, where I started with the then Director of the Coalition on Violence against Women (COVAW). Their information does not form part of the methodology of the study, but it provides a rich and important background to understanding the trajectory of sexual violence in Kenya. All the informants have been advocates within the women's movement, women's rights and sexual violence (that are interconnected) either as activists or academicians working from government, parliament, the civil society or academic institutions. They are presented in alphabetical order in table 3.1.

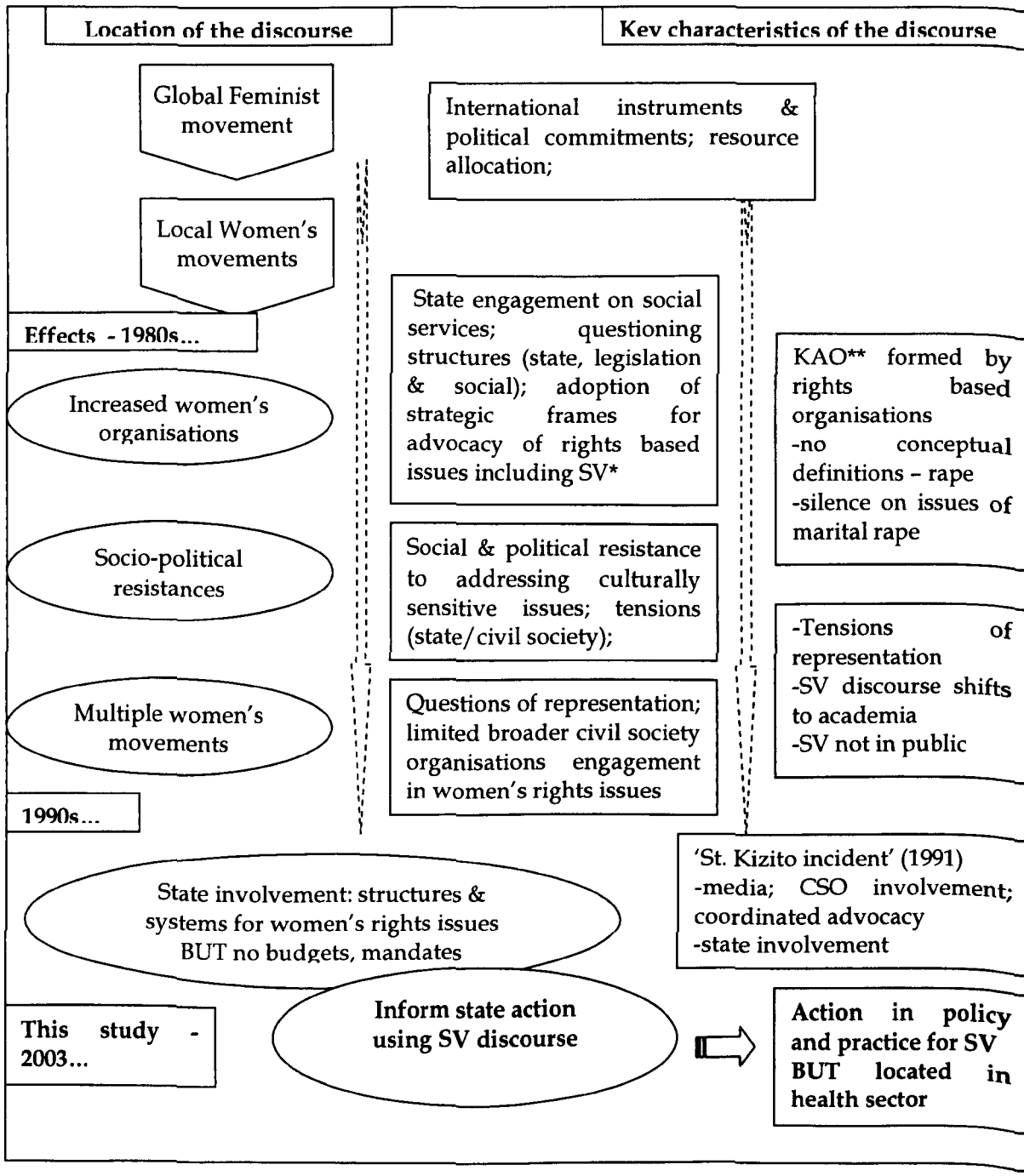
The information presented here is my summary of the accounts. I tried to minimise the possible subjectivity of these accounts, given the involvement of the informants in the movement, by anchoring the narrative to key events in time and this can be verified in grey literature as follows. The conceptual map in figure 3.1 reflects my own understanding of the discourse based on these accounts.

Table 3.1 Informants on the discourse of sexual violence in Kenya

Name: Key positions and relationship to the women's movement in Kenya	Govern-ment	Parlia-ment	Civil society	Academic institutions
Adeline Mwau: Co-founder of the Coalition on Violence Against Women (COVAW) & currently a Board member		√ (current)	√	
Anne Gathumbi: Kenya Country Programme Officer - TROCAIRE Ex - Director - COVAW			√	
Betty Muragori Gender Consultant			√	
Jacinta Muteshi (PhD): Chairperson of the Gender Commission	√		√	√
Jacqueline Olweya Currently - Gender Advisor, African Section UNDP - New York Formerly Government Advisor - Gender Mainstreaming and Empowerment Programme - UNDP supported	√		√	
Jacqueline Oduol (PhD [Professor]): Co-founder - African Women's Organisation for Research and Development (AWORD) Co-organiser - NFLS (1985) Professor of Linguistics - United Stated International University (USIU)			√	√
Jean Kamau: Gender Consultant and a founder member of FIDA (Federation of Women Lawyers - Kenya Chapter)			√	
Mary Wambua: Head - Women's Bureau, Ministry of Social Services	√			
Miriam Kahiga: Coordinator - Amnesty International Violence Against Women 8 year campaign - Kenya Formerly - Kenya Human Rights Commission			√	
Rosemary Okello: Director - African Women and Child Institute			√	

Figure 3.1 presents a map of the women's movement and sexual violence in Kenya. While it presents the various stages as distinct, in reality they overlapped and the boundaries for the change of debates are mostly unclear. Subsequent sections (3.4.1 and 3.4.2) provide detailed descriptions that portray these overlaps.

Figure 3.1 Map of the Kenyan trajectory on sexual violence



3.4.1 Western located feminism and the women's movement in Kenya

The global Women in Development (WID) paradigm highlighted in section 2.4.1 of the literature resulted in the establishment of Government machineries and structures aimed at integrating women in development[245,259]. Women's Bureau within Government and Units of gender issues with select focal points in sector ministries were created. The Maendeleo ya Wananwake Organization (MYWO) was the first Kenyan national organised women's movement with countrywide representation and is reported to have had a clear vision, leadership and direction. It was WID oriented and primarily enhanced women's ability to respond to basic social needs such as access to education, income and health. The Mexico conference (1975) catalysed the increase of more organised units of women. They began to engage government, infiltrated policy on social issues such as health and education and reportedly achieved considerable amounts of success, a much cited example being the Forum for African Women Educationalists (FAWE). Increased resource allocation to enhancing women's engagement with development during the UN women's decade (1985-95), and the development of international instruments improved organised women's movements. After the Nairobi Forward Looking Strategies (NFLS) in 1985, at the end of the Women's Decade, there was an increase in women's rights organisations in Kenya. This increase in resources and women's rights organisations appears to have had three broad effects.

First, women's emancipation and civic competence on rights issues increased women's ability to challenge social structures in which they lived. Rights based and professional women's organisations became increasingly active. For instance, the formation of the Federation of Women Lawyers (FIDA) – Kenya Chapter, was a direct result of the NFLS in 1985. These organisations primarily addressed rights issues and triggered the beginning of state engagement on rights issues [64,67]. Professionals and academics mainly worked with legislation and socio-political structures through interrogating content, institutional systems and structures in areas of law, education, health and politics. The gendered nature of political and public institutions that was skewed towards favouring males began to be increasingly questioned. The leadership position of Maendeleo ya Wanawake Organisation began being questioned by its constituency due to what was perceived as its 'resistance' to questioning the

state on rights based issues. Thus, activism aimed at women's emancipation was expressed by an influx of new organisations at local levels through increasingly powerful women's grassroots organisations such as the Kangemi Women's Centre, and at national levels. Some women representatives within the movement went on to become major figures with much political power in Kenya.

Secondly, active state and social resistance to the interrogation of existing belief systems and patriarchal cultural practices emerged. These socio-political resistances to women's attempts to make public what were considered private issues took varied forms at local and state levels including public insults by powerful political and social leaders. There was increased tension between the state and women's movements (except with the Maendeleo ya Wanawake Organisation that continued with its welfare approach and is described as having a 'cosy' relationship with the government in the 1980's). Political will for addressing sexual violence was absent. The existence of a group of socially 'unfit and unacceptable' women was often portrayed. These often had a university education, were single (unmarried or divorced/separated), urban located and were described as 'the elite'. This single status was a centre of criticism and associated with 'being a failure' in life, which can be framed in the social value attached to marriage for women. These sentiments were extended to the general public. The term feminist also began to draw negative connotations during this time. It was associated with being aligned to western ideals and values. This may perhaps partly explain the resistance by Kenyan women activists to identifying as feminists, in addition to the tensions between western located and African women's movements highlighted in literature (section 2.4).

Thirdly, there emerged multiple women's movements. The elite/grassroots or traditional/modern binaries became more apparent in the 1980s. Ngugi (2000)[64] sees this elite/grassroots dichotomy as problematic. It is unclear whether it referred to geographical spaces occupied, ability to access economic and social opportunities or levels of education. This divide metamorphosed into a question of representation. In the 1990s, it was felt that gains made in preceding decades began being eroded as focus shifted from 'what was being said' to 'who was speaking'. Such gains included the focus on rights based issues such as

sexual violence whose visibility diminished (as described in the historicity of sexual violence outlined in section 3.4.2 below). It is reported that women's organisations were also not always professionally run, due to limited management capacities and thus some organisations could not sustain funding. It is unclear to what extent the resistance to, and criticisms may have shaped the dichotomies in the women's movement. I suggest that tensions of representation by the 'elite/grassroots' or 'traditional/modern' that emerged within the women's movement can be framed in the context of social and political resistances that emerged. They may also represent socio-political power embedded in women's leadership as well as being symbolic of the socio-economic inequalities in Kenya.

3.4.2 Activism on sexual violence in Kenya

The Kenya Anti-rape Organisation (KAO) was notably the first to voice sexual violence/rape as a public concern. In 1986, Fatma Anyanzwa, then a vocal member of the Kangemi Women's Group was acting as a part time administrator of FIDA, launched the KAO. KAO aimed at increasing awareness (and therefore social action) and mobilising government support to enhance prevention and improve justice for survivors through increased convictions. Rights based and professional women's organisations such as the FIDA supported KAO's advocacy. Social and state engagement by the organisation was activism based without interrogation of legislation, culture, social and state structures. No consensus was drawn amongst advocating groups on a conceptual definition of sexual violence. Public engagement with issues such as incest and marital rape that draw on strong cultural sensitivities reportedly elicited disagreements amongst the women's organisations[260]. In an effort to draw on common ground, these 'very' sensitive issues were lost in the public domain and seem to have shifted to academia from about 1986. It is reported that scholars at the university and other research institutions continued debate on gender issues, and began to interrogate social-cultural and economic-political contexts. However, there does not seem to be much evidence in literature to support this. Academic inquiry into belief systems and political spaces occupied by women and their intersections with broader gender based violence began to be explored, albeit scantily. These works were generally exploratory and descriptive, with no pragmatic orientation[71,261]. In addition, little of this work focuses on sexual violence. It seems that much of this work did not get to the public domain and

remained in the academia, either as published literature or as grey work. The question of representation emerged strongly in late 1988 within the KAO. Two figure heads were associated with this tension that is reportedly a key factor in the collapse of KAO. Fatma Anyanzwa was seen by some members as a representative of grassroots women, while Adeline Mwau, was seen as a representative of the elite group. In addition, reports indicate that the leadership and management style of Fatma Anywanza were not professional with limited accountability of funds and no effort towards development of structures within KAO.

Between 1989 and 1991, the focus on sexual violence faltered. Drawing on the various informal interviews I conducted, it appears that KAOs attempt at increasing the visibility of sexual violence coincided with the gathering momentum of diverse socio-political resistances described above (3.4.1) to the women's rights movement in general. At the same time, the women's movement was experiencing internal tensions. On the one hand were issues that drew on sensitivities such as the question of marital sexual violence. On the other were issues of representation that resulted in political in-fighting. Sexual violence appears to have been lost from the public domain in these tensions.

On 13th July 1991, male students at St. Kizito mixed secondary school, in the North Eastern part of Kenya, invaded the girls dormitory and violently raped 70 girls and 19 girls died. The head-teacher of the school, in defence of the boys reportedly said *"...the boys did not mean any harm, they only wanted to rape.."*(Nation Newspaper 14th July 1991). There was public outrage, compassion for the victims and survivors, but what was also seen as complacency on the part of Government. This incident catapulted and forced sexual violence back to the public domain. St. Kizito Secondary School was eventually closed in September 1991. The broader civil society that is described to *"have been silent in a worrying way"*(p14)[64] on women's rights issues, thereafter converged with women's organisations to strengthen advocacy on sexual violence. Over the next decade, there was a steady precipitation of public consciousness driven by the media, donors and faith based organisations and religious institutions. It is unclear at what point the media and faith based organisations became involved in the discourse, or what has sustained the media response to highlighting sexual violence. The year 2000 onwards saw the proliferation of civil society organisations addressing sexual violence.

In 2002, advocacy groups (human, women, children's rights, medical associations), professional associations in medicine and law, health care practitioners and rehabilitation service providers, formed a network 'Komesha Unajisi Network' (Kiswahili words for 'stop rape'). The primary objective was advocacy for legislative and policy changes in prevention, care and rehabilitation. In cognizance of government's responsibility for policy formulation, legislation and services delivery the network opted for dialogue and collaboration as avenues for policy influence with targeted Ministries, namely, the Ministries of Health, Criminal Justice and Constitutional Affairs, and Gender and Social services. Network monthly meetings are reported to have allowed feedback on the political climate, government stance, and planning for synergized strategic interventions.

On the part of Government, adoption of women's rights concerns has been inconsistent, operating within a spectrum of resistance, complacency, good political will and government action. Ratification of international instruments protective of women's rights did not always translate to government support and action. For instance, the Units of Gender Issues established in the 1980s were weakened by dual roles of selected officers, limited support in policy, operational action or budgetary provision. In 1996, the government adopted gender mainstreaming and established gender focal points on an experimental basis in 1998. These were however, constrained by lack of mandates for creation of horizontal linkages amongst ministries and continued independent gender initiatives by line Ministries[245,262]. An independent Gender Commission was established in 2003, aimed to strengthen gender mainstreaming, with mandates for cross-sector linkages. With specific regard to sexual violence, changes in Government have been after the year 2000. They have reportedly been precipitated by civil society advocacy, media attention and efforts of female parliamentarians. The focus on HIV/AIDS provided a platform for advocates to query state positioning and actions on sexual violence as a means of HIV transmission. Government actions have included: an amendment to the sexual offences act in 2003, drafting of the Sexual Offences Bill currently under review by the Attorney General - 2005, Ministry of Health commitment to provision of HIV PEP in public health facilities. While it is clear that strong civil society engagement has contributed towards these changes, the significance and the degree to which this has been the case is unclear at the time of writing.

3.5 Community influences on uptake and responses to sexual violence

The perceptions and meanings of coerced sex in Kenya are varied. Adolescents seem to distinguish between rape (that associated with a stranger) and coerced sex (that often associated with known males and acquaintances). Erulkar's (2004)[254] study showed that intimate partners - boyfriends and husbands were the most common perpetrators of sexual coercion. Ideologies of masculinity among Kenyan men (adult and young) were largely associated with sexual coercion and force. In the St. Kizito school incident the head-teacher adopted a casual approach to the incident that has been cited to reflect the acceptability and normalisation of sexual violence as a form of domination and control[261]. Njue et al (2005)[258] suggest that using force is an integral part of the seduction process for boys in Kenya, with young men in group discussions admitting having 'pressurised' girls to obtain sex. 'In-depth' focus group discussions with adolescents in Kenya revealed that coercion of female partners was common, where boys admitted seducing girls first and if this fails, they use force[254,263].

Age at marriage has been associated with vulnerability to sexual violence. Erulkar (2004)[254] suggests that marriage may increase the risk of sexual violence and HIV infection in Kenya. In her study, 45% of the married respondents had been coerced by their husbands. Women in steady sexual relations and adolescents do not perceive themselves at risk of HIV infection[247] and in many contexts do not have the power of choice over the situation. Fear of the social repercussions and lack of legal redress are barriers to women leaving abusive relationships. There seem to be differing views on women's emancipation and links with sexual violence.

Sexual coercion seems to be associated with the increased likelihood that first sex was with persons at least five years older[254]. Cultural and customary practices, gendered expectations confer considerable power in sexual decision-making in men. Sexual violence by brothers of their dead brother's spouse has been documented in Kenya. Women in these settings lose their (husband's) property and are often themselves "inherited"[256]. Jewkes (2002)[264] sees much sexual violence taking place in marriages and families as being supported by a cultural approval of rape as a strategy for control and discipline of women. Marital customary practice does not protect women's vulnerability to violence. Regarding dowry for example,

Kenyan authors Nyamu and Gachii (2000)[260] note that *"payment of dowry reinforces notions of male ownership and sex rights over women and further devalues the dignity of women and makes it easier for coercive or violent conduct of men to be tolerated"*(pxx). Key informant discussions by Njue (2005)[258] revealed that men who have had intercourse with their daughters justify their behaviour by blaming their daughters, wives or prevailing HIV situation. Girls are perceived as 'looking like their mothers, hence tempting their fathers' while women will be blamed for failure in their sexual and familial relations.

3.6 Institutional factors: gaps in the legislation

As noted in the trajectory of sexual violence in Kenya (3.4.2), Government action towards sexual violence increased. In November 2006, a new Sexual Offences Bill was enacted. It addressed some of the challenges in the previous act that I outline in this section. I utilise the definitions of the Act prior to 2006, as this was what informed the study.

3.6.1 Sexual violence as defined in the Kenyan legislation

Sexual offences are captured under the penal code in the Kenyan constitution (CAP 63, sections 139; 141; 144; 145; 162), thus are a crime against the state. Some of the offences mentioned include rape, indecent assault, defilement, incest, sodomy and unnatural offences, described as follows (2):

- **Rape** (s. 139) constitutes carnal-knowledge (3) (penile-vaginal penetration), of a woman above sixteen (16) years of age, without consent and obtained by use of force, threats or intimidation of any kind, fear of bodily harm, or by means of false representations as to the nature of the act.
- **Indecent assault of females** (s. 144) constitutes words, sounds, gestures or exhibition of object intending that these are heard or seen in a way that intrudes the privacy of a woman or girl or insults their modesty

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[2] These descriptions have been adapted without the legal language used in the constitution and discussed with two lawyers to ensure that meaning is not lost.

[3] *Carnal knowledge* has been interpreted as penile-vaginal penetration within legal discussions. While the anus and oral cavities are canals, this assumption is because when these other cavities are mentioned, the words 'against-the-order-of-nature' are added to them in the context of the law

- **Defilement** (s 145) is defined as carnal knowledge of girls of below sixteen (16) years of age is considered defilement. The issue of consent does not arise and a person guilty of this felony is liable to life imprisonment with hard labour.
- **Incest** by males (s.166) of females (s.167) Is the carnal knowledge of a female or male who is to their knowledge grandparent, daughter, son, sibling, parent. Consent is immaterial.
- **Sodomy** (s.164) Sodomy is occasioned by the anal penetration of boys of below 14 years and the issue of consent does not arise. Sodomy was included as part of the criminal law amendment bill of September 2003.
- **Unnatural offences** (s.162) constitute of carnal knowledge of a person against the order of nature (4), carnal knowledge of an animal; or permits a male person to have carnal knowledge of him or her against the order of nature.

At that time there were concerns with the law. I was able to informally discuss with two human rights lawyers (involved in sexual violence work in Kenya) and use their perspectives to draw some challenges that negatively influenced health service uptake and delivery.

- The definition of rape (penetration of the vagina by the penis) was limited. There is no distinction between forced anal and consensual anal sex of men and women, as they would all be criminalized as 'unnatural offences'. The law excluded all forms of sexual violence towards males of above 14 years of age and the use of items such as bottles. Legally, men of above fourteen (14) years in Kenya could not be sexually violated. *These issues were addressed in the new Act, 2006.*
- Laws developed to punish sexual violence/rape are usually interpreted to exclude sexual violence in marriage as there is no explicit provision. *This remains a challenge.*
- Rape has a clearly defined maximum penalty (life-imprisonment) but no minimum sentence. *The current Act has minimum sentences*
- Regarding the judicial system, there were parallel clan-based and largely patriarchal traditional systems of conflict resolution that reportedly mediated cases of sexual violence.

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[4] *Against the order of nature*: The presumption of the law that sex should include opposite sexes and include a penis and vagina and that this is natural. Therefore where this sexual activity (including penetration) is done beyond these boundaries, then it is regarded as being unnatural and described as 'against the order of nature'

Fines and penalties for perpetrators were known to range from a chicken, a goat (worth about $15) or the forceful marriage of the survivor.

3.6.2 Protocol for engaging the criminal justice system

Ideally, the criminal justice system should complement health sector evidence provision through recording survivors' statements, evidence collection from crime scenes, investigation, arrest, litigation support through testifying in court. I held informal interviews with an Assistant Police Commissioner mandated with women, family and gender issues and a lawyer working with the FIDA. They provided the information in box 3.2 on the expected reporting protocols that I summarised. It was however difficult to obtain written documents on reporting protocols, police responsibility and mandate in cases of sexual violence.

Figure 3.2 Expected protocol for services delivery by the criminal justice system post sexual violence

1. A survivor should report at the nearest police station
2. The police should record a statement and the survivor signs the statement
3. A P3 form (this is the legal document used as primary evidence in court and has to be signed by a medical officer) should be availed.
4. Survivor should be accompanied by a police officer to the hospital where clinical evaluation is undertaken and the police officer returns with a signed P3 form and evidence collected from the survivor.
5. Ideally, a police surgeon should undertake examination and documentation
6. An investigation is then commissioned, the alleged perpetrator arrested and a litigation process ensued.
7. Police provide supplementary evidence to health sector evidence
8. The judiciary should provide a state prosecutor and the survivor should avail themselves as the defendant in court. A judgment and a sentence is passed

especially those violated in their homes is a key challenge to rehabilitation of rape survivors. There are only two rehabilitative centres for sexual violence in Kenya.

3.7 Institutional influences: health sector reforms

Decentralisation and reforms have significantly influenced, and provide a background against which to discuss health sector organisation. Between the 1980s and 2000, health sector performance in Kenya deteriorated. Recurrent health expenditures fell from 9.26% in 1986 to 7.61% in 2001, constraining health delivery[265]. The move towards decentralization of financial

systems and decision-making structures in the 1980s was part of broader health sector reforms noted in literature (2.8.1). Health financing alternatives included introduction of cost-sharing. Income from cost sharing at the health facilities accounts for 3% of the health budget[266]. It was aimed at supporting primary health care and strengthening clinical performance of the facilities and other services delivery aspects. These cut-backs in health and introductions of user charges hit women hardest as the primary providers and consumers of health/social services. Subsequently there was limited ability to share health costs, thus reducing the intended efficiency of health sector reforms[171,267]. On the other hand decentralisation meant increased district authority and autonomy for decision-making, resource allocation and management of health care to the district and facility levels, thus enhancing citizen participation in health care.

Decentralisation of decision-making structures involved a gradual process of moving power and authority from the centre (national level) to the periphery (district). District Health Management Teams (DHMTs) comprising technical health staff, were established as the focal points to prioritise and manage health services. To increase public representation in planning and monitoring of health care, overseeing cost-sharing activities and approving management team expenditure plans by DHMTs, the Government introduced District Health Management Boards (DHMBs). These are further discussed below (3.7.2). At the national level, the National Health Sector Reform Secretariat (HSRS) was established to spearhead the reform process. In the context of the gaps in government capacity for delivering health care private sector and civil society became actively engaged in service delivery accounting for 56% of health care by 2000 in Kenya. This influx of actors and the influence of multiple policy structures (vertical and horizontal programmes) led to the emergence of multiple and parallel systems of service delivery at national and local levels that continue to be a challenge for health sector coordination[217,268,269] (annex 2).

In the 1990s Kenya moved towards development of a national health sector strategy. In 1994, the Kenya Health Policy Framework Paper was developed. The overall goal was to promote and improve the health status of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable. Progress on

the implementation of the health policy framework paper was reviewed in 1999. A National Health Sector Strategic Plan I (NHSSP I) 1999-2004 was developed to operationalise the policy framework. In 2005, the gains and challenges of the NHSSP I were reviewed and the second National Health Sector Strategic Plan (NHSSP II - 2005-2010) was developed. Various challenges were identified in the NHSSP I that had hampered its implementation:

- Poor systems development with un-harmonised work plans and unevenly followed reporting and feedback tools and mechanisms.
- The dominance of vertical thinking and action resulted in parallel plans, reports, working targets, independent and uncoordinated monitoring and evaluation in the districts and provinces.
- Weak knowledge of financing mechanisms, resource 'envelope' requirements and allocation systems and, thus limited linkages between plans and national budgets.
- The absence of a legislative framework to support health sector decentralisation was cited as a key constraint.

In about 2000 Kenya was reported to be at the beginning of the SWAps continuum[245]. The NHSSPII - 2005-2010 was conceptualised and development within a background of government commitment to moving towards SWAps (2.8.1). The health sector reform secretariat was mandated to implement appropriate structural, financial and organisational reforms in the NHSSP II within the SWAp, a process that is on-going.

3.7.1 Structures for health care service delivery in Kenya

The information that makes up this section was triangulated from the NHSSP I & II, and informal interviews undertaken with an officer from the Health Sector Reform Secretariat. It was corroborated by a programme officer at the Division of Reproductive Health. Health care in Kenya is organised into 6 levels [1-6] respectively; community, dispensary, health centre, primary hospitals (often district), secondary (provincial) and tertiary (national). The Ministry of Health is continuously moving towards implementing the SWAp in Kenya.

The hierarchy of health providers in Kenya is made of Medical Officers who are trained Physicians. They provide the entire range of external, internal and auxiliary medical services to inpatients and outpatients including surgery. Clinical Officers are a cadre of health care

providers who have been trained at diploma level in medicine and provide diagnosis, treatment and auxiliary services. Nurses fall into two categories, Registered Nurses and, Enrolled Nurses with the former having higher qualifications. They primarily provide on-going inpatient and outpatient care, diagnosis for a limited range of illnesses and facilitate referrals. Additional staff are trained to provide auxiliary services including radiology, physiotherapies, laboratory technical support, health records and information maintenance. All these personnel are employed in varying scales of the Civil Service.

Health care in the Province and District is headed by the Provincial and District Medical Officers of Health respectively. Each hospital is headed by a medical superintendent who is also a medical officer. Many sub-district and health centres (level 3 health care services) are headed by clinical officers. Most dispensaries are headed by Registered Nurses. All these categories of service providers are commonly referred to as clinicians. All the heads of the various health facilities act not only as frontline health providers, but as administrators and managers of the different facilities they run.

District Health Management Boards were established to oversee health management at district as the 'public watchdog'. They however faced challenges of representation by age, wealth, education. In particular women's lack of representation and participation have been questioned[245]. An imbalance of information and power between the Boards (made up of public) and the DHMTs (made up of technical personnel) has often led to health workers controlling the committees with DHMBs being described as 'inconsistent and ineffective', with limited capacity to undertake their functions[246,270]. In 1999 DHMBs were given greater responsibility and authority to oversee planning, governance, management and development of health services, and the allocation and distribution of government and health resources generated from user fees, and to make recommendations on expenditures and budgets to District Development Committees (DDCs)[246,271]. However, the challenge of their lack of ability to control the DHMTs still remains.

3.7.2 Policy formulation and decision-making

In the context of decentralisation and the adoption of the SWAp, stakeholder collaboration was accepted and has been promoted within the Ministry of health[272]. Policy formulation and national planning in government ministries are increasingly done through multi-disciplinary committees comprised primarily of government, civil society and funding partners[273]. These partnerships have reportedly facilitated government access to increased technical, organizational and financial capacity (personal communication with the programme manager Division of Reproductive Health). At central Ministry of Health (MoH) level, the Joint Inter-Agency Coordination Committee (JICC) is chaired by the Minister for Health. At the level of Departments and Divisions that coordinate policy formulation and implementation, inter-agency coordination committees (ICCs) support operations, monitoring of national progress and creating effective synergies. Policy, planning and services delivery uses primarily a bio-medical approach with budgetary, policy and operational focus on curative services. The NHSSP I had a commitment to relocating health resources to favour the rural population and women. However, like in many African countries there remains inadequate re-orientation of capital budgets towards primary and preventive health care that would benefit women and rural populations[168]. The review of the NHSSP I identified these contradictions, and in the NHSPPII, the Division of Reproductive Health that is charged with among other things maternal and child health services (table 3.1) received the highest levels of annual budgetary allocations from the resource envelope through the five years of the plan[273].

The responsibility for gender mainstreaming in the Ministry of Health, is with the Division of Reproductive health. A working group, the Gender and Reproductive Health Rights Working Group is expected to mainstream gender in the Ministry of Health and to develop synergies with other programmes. However, limited capacity for gender mainstreaming, and lack of horizontal/intra ministry linkages is a constraint for the working group, as reported by the Head of the Group (Dr. Margaret Meme). In addition, focus has tended to be on specific reproductive health rights issues/concerns including female genital cutting and sexual violence. It is therefore this department that is responsible for policy formulation, implementation and scaling up of post rape services in Kenya.

In table 3.2, I summarise the management, structure and functions of the central MoH level, the two policy formulation and implementing arms, the Division of Reproductive Health and the National AIDS and STIs Control Programme(NASCOP). This summary is based on my analysis and understanding of the MoH, gained from literature and informal discussions with health service providers and policy makers. I selected these two Divisions based on their relevance for delivery of post rape care services in Kenya.

Table 3.2 The MOH functioning

	Management	Structure	Functions
Central Ministry of Health - Headquarters	1. Minister for Health -Final decision maker -Represents health concerns at Cabinet, in parliament & internationally -Chairs the JICC 2. Permanent secretary -Chief Accounting officer 3. Director of Medical Services -Technical advisor to Minister & PS	Divided into 4 departments -Curative and rehabilitative -Diseases prevention and control -Maternal and Child Health -Policy and coordination Further divided into 30 divisions that: -Are implementing arms -Provide policy guidance & facilitate implementation for specific services delivery -Are links between the centre & the provincial and district	-Coordination for meeting national health goals -Engagement with Ministry of Finance -Health sector resources mobilisation -Policy formulation -Decision making & macro planning -Regulatory control, -Human resource development -Donor relations
Implementing arms **Division of Reproductive health (In the Maternal and Child Health department)**	1. Head of Division -Chairs RH-ICC (which is the decision making body for the Division and links to other government institutions and bodies). The ICC comprises donors, civil society, private sector undertaking reproductive health research and implementation. The ICC has 7 working groups 2. Programme managers 3. In charge of each working group	Policy formulation & oversight done through the RH Working Groups: -Family Planning -Safe Motherhood -STI -Cervical Cancer -Infertility -Monitoring & Evaluation -Policy and advocacy -Training, Protocols and guidelines -RH-Research Gender & RH-rights (post-rape care falls in this working group)	DRH - charged with all RH aspects of health care -Provide guidance on priority areas & gaps -Oversee quality & coverage -Promote & develop standards, capacity -Support research in RH and HIV/AIDS interventions -Mobilize resources -Coordinate partners in provision of RH services
National AIDS and STIs Control Programme (NASCOP) - (in the Disease prevention and control Department)	1. Head of NASCOP 2. Programme Managers 3. Programme Coordinators	Has Task Forces for policy formulation and oversight: -VCT, -Diagnostic counselling & Testing -Anti-retroviral Therapy -Prevention of Mother to Child Transmission -Home-Based Care	NASCOP-(similar functions) charged with Bio-medical & public health HIV/AIDS interventions

In addition to the NASCOP responsibility to the MOH, NASCOP is also accountable to the National AIDS Control Council. The National AIDS Control Council (NACC) of Kenya coordinates the national HIV response, within the framework of the '3-ones' - one coordinating mechanism, one strategic plan and one monitoring and evaluation framework. All partners and stakeholders in Kenya that contribute towards HIV/AIDS policy formulation and service delivery are required to respond to the Kenya National AIDS Strategic Plan 2005/6-2009/10 (KNASP II). The KNASP II focuses on three priority areas: 1) Prevention of New Infections, 2) Improvement of Quality of life and, 3) Mitigation of socio-economic impact. It identifies 6 vulnerable groups that require targeted responses. The operationalisation of the KNASP II relies on: a) Monitoring and Coordinating Groups - committees for each priority area - that provide direction, monitor and report on the progress, b) the NACC steering committee that supports policy formulation, decision making and provides direction to the coordination role of the NACC, and c) the Joint Annual AIDS Peer Review (JAPR) process that annually monitors progress of the KNASP II against the indicators set in the National M & E framework. The MOH is charged with the responsibility of delivery of priority areas 1 & 2 that focus on socio-medical interventions of prevention, treatment and care services. The National AIDS Control Programme and the Division of Reproductive Health are responsible agencies in the Ministry of Health.

The Provincial Medical Officer of health manages health matters in each province. Provincial Health Management Teams approve district health priorities and expenditure plans, ensure reporting of health indicators, monitor and evaluate district performance. They oversee policy implementation and provide feedback to the national level[246,274]. Oyaya (2003)[275] however, sees the province as lacking capacity and resources to manage districts. To enhance service delivery, departments/divisions have developed working teams at provincial level, for instance, Provincial Reproductive Health Teams, the Provincial AIDS and STI Control Officer and the Provincial ART (anti-retroviral therapy) officer for Reproductive health, HIV/AIDS and ART programmes respectively. Their mandates include coordination, training, supervision and reporting of programme progress and activities.

The District Medical Officer of Health is in charge of all health services provision in the district. District health management teams support the Medical Officer of Health in planning, implementing and monitoring all health activities in the district and reporting to the province. They generate and control expenditures of voted financial resources and donor funds. District hospitals are run by the Medical Superintendent who is also a medical doctor, and managed by a hospital management team that is responsible to the district health management teams.

Private and non-government providers account for 56.7% of health services[273]. In an effort to support delivery of health services, civil society actors have put in place multiple structures and processes that often run parallel to government service provision at grassroots and health centre levels[276,277]. The District Health Stakeholders' Forum (DHSF) is an inter-agency coordination team that should exist at the district level. It should consist of all health related organizations (NGOs, CBOs and Government Departments). It should support formulation of comprehensive district health plans, enhance collaboration and efficiency of human, technical and financial resources, strengthen coordination and reduce duplication of efforts. However, in reality this forum is mostly non-existent and lacks a policy framework and budgetary support thus is functional only in some districts, often supported through external donor funding[245]. While it offers a considerable potential for linking health and other necessary services for post-rape care such as the police, concerns include sustainability and the varied stakeholder foci and objectives. It has also been seen to have the possibility to become another bureaucratic loop through which health actors must leap at district level[278,279]

3.7.3 Challenges for health sector reforms and services delivery

Research highlights problems of infrastructure, lack of accountability and coordination (inter-government and between stakeholders), poor planning and prioritization as challenges to effective functioning of the health sector[168,280]. Policy reform and implementation are not systematic. Oyaya (2003)[281] raises concerns on the background against which reforms have been carried out. Government and donor expenditure in health have increasingly diminished, and most government funding is allocated to staff salaries with few resources for operational and strategic services. Poor working conditions and limited training for health workers are

de-motivators for staff. Irregular supplies of essential drugs, equipment in the health facilities, increased problems of staffing are realities that remove services away from users and providers. Gilson (1995)[282] sees the failure in health reforms largely as a result of stressing outcomes at the expense of processes in Kenya as well as other sub-Saharan region countries [276,283,284].

The DHMT is seen to lack capacity to implement and regulate new services, with members who are service providers rather than health managers[285]. Concerns about the multiplicity of parallel implementing structures, programmes whose objectives and activities are unclear and duplication of efforts add to the complexity of district health coordination. Government lacks functional regulatory, standardisation and supervision mechanisms to ensure focus of all stakeholders on national goals and visions[286]. The mandates and interests of many civil society organisations do not reflect community, district or government health sector priorities. They have been seen to *"increase the potential for conflict, replication and confusion between NGOs, government and communities"* [287,288].

There are no clear systems to judge the worth of on-going programmes and estimate the usefulness of attempts to improve them, assess the utility of innovative programmes and initiatives, increase the effectiveness of programme management and administration[224,246]. It is therefore difficult to estimate the feasibility of health services introduced into the system. Odhiambo (2005) sees a need to stratify accountability requirements of programmes and evaluations, in order to meaningfully contribute to substantive and methodological social science knowledge and effectively link what are seemingly disparate health services provided in the same health services[224].

3.8 Health sector responses to sexual violence

In this section, I draw on the background of the health sector and its current structure and information that I acquired during informal interviews with health managers at the DRH and NASCOP (3.8), the police and legal practitioners (3.7), and the women involved in Kenya's women's movement (3.4). I frame these discussions within the context of the VHA framework, complemented by the ecological model.

3.8.1 Responses to biological (micro-level) influences of sexual violence

Management of injuries was undertaken in accordance with standard protocols depending on the nature and type of injury at health facilities in Kenya. Referral to specialist services or in-patient treatment was undertaken for those injuries that could not be managed at casualty or outpatient departments.

Emergency contraception was provided consistently in private health facilities and one donor supported private service centre - the Nairobi Women's Hospitals. Provision of emergency contraception appeared to be dependent on specific health care providers, and whether or not they were aware of the services.

HIV PEP was provided as triple therapy within the private health sector. It was not established whether this was in all facilities or a few. Within the public health sector, providers were not familiar with HIV prevention following exposure. HIV PEP was expensive in comparison to the price of other ARVs in 2002 at about three times the cost of other ARVs, and was not provided by the government. In addition, the capacity in information, skills and facilities to undertake requisite tests for PEP indication such as HIV test and manage PEP, given the toxicities cited in literature at the time, was lacking.

STIs treatment was offered in health facilities through the STI clinics, whose reporting was reported to be vertical through the NASCOP. This was reserved for syndromic management only that was determined through analysis of the high vaginal swab taken during examination of survivors. Thus, where no pre-existing STIs were found, survivors were sent home and asked to report back for clinical evaluation and screening after two weeks. There was no mechanism for tracking follow-up thereafter.

Counselling was offered inconsistently in health facilities in Kenya. Diagnostic counsellors who were expected to provide support to survivors of sexual violence were often untrained for sexual trauma and more so in the context of HIV testing. Counsellors available within health institutions are primarily those trained to undertake voluntary counselling for HIV testing. VCT for HIV in Kenya is a prevention strategy and an entry point for HIV care and anti-retroviral therapy (ART). Protocols and standards for VCT implementation, reporting

mechanisms, and quality assurance systems and monitoring frameworks were in place in Kenya, supported through the NASCOP. VCT had been rolled out as an integrated part of health care infrastructure since 2001. VCT was the only existing organized counselling infrastructure in the health care system with counsellors who received standard training, regular counselling supervision support. Counselling in the context of rape was offered through professional counselling institutions, located outside of the public health sector. Professional counselling designs offered by the Kenya Association of Professional Counsellors were often aimed at long-term on-going support, with no consideration for short-term HIV testing and PEP requirements.

VCT is managed through the National AIDS and STI control programme. There was and still (at the time of writing) is no cadre for counselling in the Ministry of Health. The lack of a professional career path for counsellors was seen to translate to dual roles for VCT trained counsellors.

3.8.2 Institutional responses (macro-level factors) to sexual violence

Ideally, examination, evidence collection and documentation should be undertaken by police surgeons at the police station. However, there was only one police surgeon in the country who was available only in Nairobi located at the traffic headquarters (as they also were mandated to examine and provide documentation for traffic and other assault related offences). Given that context, medical doctors undertook examination, documentation, evidence collection and court witness duties. Doctors in the public health sector, particularly those located outside of Nairobi (where the police surgeon was based) were expected to fill in the P3 form (5) and give legally admissible evidence in court.

Kenya experiences staff shortages, as in most developing countries (2.8). These shortages at health facilities (3.8.4) placed the responsibility for examination on nurses and clinical officers to support the few medical doctors, and they had no prior training in medico-legal examinations and documentation. Results of physical examinations that centred on the

[5] P3 forms are legal document found in police stations that Doctors fill on examination of rape survivors (and in other assault cases). These are used as medical evidence during investigation and prosecution processes to prove, corroborate or at times dismiss the assault case. They form the basis of prosecution and are a crucial part of evidence and documentation.

perineum were recorded on patient cards and this information transferred to the P3 form. This increased the potential for evidence loss in transfer of data from the clinical officers to the medical officers and then to the P3 form as well as adding a bureaucratic loop to information transfer at the health facility level. Further, documentation done on patient cards at the health facility left the facility with no records of the assault.

Specimen collection: It was noted that mainly high vaginal swabs were collected and sent to the laboratory for analysis. The principal assumption was that spermatozoa are a definite indicator of rape. Challenges posed by this assumption occur where objects other than the penis were used, condoms were used, there is no ejaculation or penile withdrawal was done. Speculums, swabs and preservation bags were not available at the designated points of presentation and time was taken as they were collected from the hospital amenity wards or the central sterilising departments after presentation by a survivor

Client flow systems: There were no defined client referral pathways, nor national standards for survivors to receive the range of services required to mitigate the negative physical and mental health outcomes for sexual violence.

Chain-of-custody-of-evidence: Evidence handed to the police was not signed for neither were records available for proof of such transfer. P3 forms signed by doctors are not signed for when handed over to the police. The integrity of the evidence chain was reportedly further complicated by the lack of a connection between the police (as the custodians of evidence), the health facility (collectors of evidence), the Government chemist (where analysis should be done) and the courts (consumers of evidence). Location of these services in different Ministries, *re,* Office of the President, Health, and Justice and constitutional affairs, respectively, added bureaucratic challenges. This was attributed to the disparate functioning of government systems identified in section 3.2.1. The logistics of transporting evidence for analysis at the Government chemist in the context of limited resources and lack of accountability mechanisms posed challenges for preservation of, and responsibility for evidence.

Data and record keeping: There were no records available at the health facility for survivors as documentation was done on patient cards. There was no link to the health management and information system as sexual violence was not captured in the national health systems as a health concern. Thus, there were no reporting requirements and indicators for sexual violence within the national reporting system.

Availability of services and costs: Survivors were required to pay for drugs and services through cost-sharing mechanisms in public institutions6. There were no specific government guidelines on costing post rape services. In the private sector, charges are dependent on each health facility. These may include consultancy fees (charged to see a physician), fees for the different tests necessary and for drugs.

3.8.3 Capacity for post rape care services delivery

Table 3.3 below outlines the various services that were required for providing post rape care services as identified in the literature (2.5) and their locations within the MoH in Kenya. In addition, I provide my understanding of the delivery service modules for these services that were confirmed as representing a true picture of the situation with Programme Managers at DRH and at NASCOP.

[6] It was difficult to establish the specific charges in this study as it was said to vary and depend on the different types of services offered. For instance, charges for STI treatment would depend on whether screening was done or a routine prescription was offered, whether any lab tests were undertaken, and what regimen was prescribed.

Table 3.3 Location and service delivery module for post rape care services

Service required	Location of responsibility at MoH (department)	Service delivery location at local level	Service delivery module
Injuries management	--	Casualty	
Legal documentation	--	Examining Medical Officer	
Laboratory services (specimen analysis)	National Reference Laboratories	Local Laboratory	Integrated services
Emergency contraception	DRH	MCH/FP* clinics	Integrated services
Counselling services	NASCOP	VCT/DCT & HIV Care Clinics	Vertical
HIV testing	National laboratories/NASCOP	Local Laboratory	Vertical
HIV PEP	NASCOP		
STI prophylaxis	NASCOP/DRH	STI clinics	Vertical
Data and records management	MoH Monitoring and Evaluation Unit	District Health Records Information Office	Integrated through the Health management Information system

Key: *MCH - Maternal and Child Health *FP - Family Planning

The differing locations of services for the range of services required provided challenges for the delivery of a post rape care package. Different reporting requirements and monitoring systems as a result of differing horizontal and vertical programmes increased the complexities of developing a post rape care service in Kenya. Issues of poor training, low staff morale, shortages in staffing were a challenge. Further, the horizontal and vertical nature of programming was problematic in as far as there was no attempt at complementing the systems at national level.

The scale up of HIV anti-retroviral therapy (ART) and HIV care services provided an opportunity for increased capacity for HIV PEP management. The existence of National Guidelines for ART management that comprised of a sub-section on PEP provision for occupational exposure facilitated training and enhanced legitimacy of PEP delivery in Kenya. In addition, scale up of anti-retroviral therapy availability meant increased access to PEP through regular ART procurement and disbursement systems. There was however, no

information on adherence to ART in Kenya and systems to increase adherence to ART were just being developed.

3.9 Liverpool VCT, Care & Treatment (LVCT) Kenya

LVCT is a non-profit, Non-Governmental Organization (NGO) in Kenya. It was founded as a project of the Liverpool School of Tropical Medicine (LSTM) in 1998 under the British Department for International Development (DfID), funded HIV/AIDS Prevention and Care (HAPAC) project. LVCT began as a research study in Kenya. Three VCT sites aimed to analyse the feasibility of setting up VCT in primary health care were established that were later expanded and scaled up in health care settings in Kenya after evidence that this was possible. These data are available from Dr. Miriam Taegtmeyer, the first Executive Director of LVCT as part of her PhD, which was in writing up stage at the time of writing this thesis and therefore cannot be presented here. However, there is evidence of scale up of VCT services supported by LVCT in Kenya described in reports of the Joint Annual HIV/AIDS progress review. In 2000, LVCT was registered as a Kenyan NGO and currently maintains an academic link with Liverpool School of Tropical Medicine through its Policy and Performance Department.

LVCT is governed by a Board of Trustees that approves strategies, annual plans and acts as the final decision maker in policy matters. The Director is the executive manager. At the time of starting this research study LVCT had a staff of 66 and was divided into 6 key departments - Finance and administration, HIV care, Counselling, Supervision and Quality Assurance, Consultancy Services and Training. Some research activities had been undertaken, but there was no 'Research' Department that had resources, was staffed and had a structure. Each department was headed by a senior manager (3 women and 2 men) who was responsible for planning coordination of activities, proposal development, staff delegation and motivation. Strategic planning was led centrally by the Director, at that time Dr. Miriam Taegtmeyer and budgets were managed centrally.

During the study period (2003 - 2006), LVCT developed and grew in programmes, activities, organizational structure, budget and staffing levels. At the time of writing this thesis

(February 2007), LVCT had a new organisation structure (annex 3), 156 staff members with 2 regional offices in Nyanza and Eastern provinces covering those areas in delivery of HIV services. This structure (currently in use) reflected the capability and core competencies developed over the years. LVCT continued to promote HIV counselling and testing services, and expanded the HIV treatment and care programme.

3.9.1 Funding for this study

The first part of this study (objective 1) was funded through the HIV/AIDS knowledge programme of the Liverpool School of Tropical Medicine between October 2002 and June 2003 at £12,000.00. This initial work, led to the development of the intervention which forms objectives 2 & 3 of this study. TROCAIRE, an Irish funding agency funded the study primarily as an intervention programme rather than strictly a research study for Euros 90,000.00. Within this budget, one item line provided funds for targeted research activities such as training of research assistants, data collection and reporting and was worth 15,000 Euros. The funding period ranged from October 2003 to December 2004 (between July and September 2003 funding for my salary, writing up expenses and initiating entry into the study districts was provided by LVCT). At the end of the reporting period, TROCAIRE renewed the funding for a two-year period (January 2005-December 2006). In 2005 and 2006, Euros 220,000.00 were granted aimed at expanding the programme using lessons learnt from the intervention in the three districts.

3.10 The study districts

3.10.1 Thika District

Thika District is in the Central province of Kenya, covers a total area of 1,906.2KM2. It borders Nairobi city making it a peri-urban area serving both rural and urban populations. It has 6 administrative divisions, a population of 701,664 (351,511 males and 350,153 females) and 2 distinct topographies. Thika is an industrial district with good communication network, availability of raw materials and a market. HIV/AIDS prevalence is 34% in Thika, with over 60% bed occupancy in hospitals. Majority of those infected with HIV are females aged 20 - 49 years[289].

Thika District Hospital covers an area of 70M2. Located next to the hospital is the Thika Medical Training College that trains clinical officers and nurses. The hospital has a staff of 92 (whose disaggregation by cadre was not available). It was however reported that there were few medical officers in comparison to the work load and were thus involved primarily in in-patient care, acute care and surgery. Thika district hospital had a bed capacity of 250 and experienced a through put of 700 patients per day (in and outpatient).

3.10.2 Malindi District

Malindi District is in the Coast province of Kenya, covers an area of 7,605 KM2 and is divided into 3 administrative divisions. The ocean coastline has good beaches for tourism and fishing activities that have positive effects on economic growth through employment creation and promotion of socio-economic activities. The District population is approximately 305,143 (154,304 male and 150,839 female) with a high population in Malindi town compared to other areas in the district. The district's HIV/AIDS prevalence rate is 15%-17% and is attributed the existence of prostitution (sex tourism), drug use including alcoholism and traditional practices such as 'wife inheritance'. Gender inequality is experienced in education, health care, economic activities, land and other property ownership[290].

Malindi District Hospital is located in Malindi town with a staff of 68 at the beginning of the study. There were 4 medical officers at the beginning of the study, who were also holding administrative positions and thus were focused on in-patient and acute care and surgery. The hospital had a bed capacity of 100, with a patient through put of approximately 400 patients per day.

3.10.3 Rachuonyo District

Rachuonyo District is in the Nyanza province of Kenya and is divided into 3 administrative divisions. Part of the district borders the Lake Victoria where there is a robust fishing industry for domestic and sale to the nearest city, Kisumu. Much of the district is rural, with a poor population. Nyanza has the highest HIV burden in Kenya with large disparities ranging from 20% to 50%. The lakeshore areas and fishing communities have the highest HIV

prevalence[257]. The District population is approximately 212,300 people. Like many parts of Kenya, gender inequality is experienced in education, health care, economic activities, land and other property ownership[291].

Rachuonyo District Hospital is located in Oyugis town centre on the Kericho-Kisumu highway that connects the Kericho tea growing town, to the city of Kisumu. Rachuonyo is a relatively new district created in 2001. Rachuonyo District hospital had a staff of 36 having been a sub-district health centre that was upgraded into a District hospital. There were 2 medical officers and 4 clinical officers at the beginning of the study. The medical officers were both holding administrative positions. The hospital had a bed capacity of 30, with a patient through put of approximately 160 patients per day.

3.11 Contextualising the rights discourse and health sector responses to sexual violence

In this section I attempt to contextualise and explore the intersections between the sexual violence trajectory and the health sector.

Literature and mapping the sexual violence debate in Kenya highlighted the vulnerability of women and adolescents (3.3.1-2; 3.65), the normalisation of sexual violence (demonstrated by reaction to the St. Kizito incident [3.4.2]) and role of social structures (3.6) in reinforcing these vulnerabilities. The trajectory of sexual violence in Kenya provided the backdrop that highlighted actions of the women's movement towards addressing these concerns. The global feminist movement provided local feminisms with frameworks for advocacy against sexual violence (3.4). Interrogation of state positioning (3.4.1) as well as holding Government accountable to commitments made for addressing sexual violence.

It was the activists of the early (1980s) who challenged social systems and brought sexual violence to the public domain (3.4.1) that seems to have opened up spaces for advocacy. Much of the advocacy was aimed at changing social structures through legislative changes. At that time there was no focus on health sector responses. The questions of representation that seemingly shifted the sexual violence debate to academia challenged the cohesion and common consciousness of the women's movement. However, they also provided an

opportunity for professional engagement with issues of sexual violence that opened spaces for a range of gender advocates including those in professional sectors. This appears to have shifted civil society towards strategic alliances with government. In the late 1990s and 2000, it was civil society's own realisation of the need for dialogue and collaboration with government that seemingly garnered commitment from the Ministry of Gender (3.4.2).

The political focus on HIV/AIDS provided spaces for feminists/gender advocates to engage government on issues of sexual violence and beginning to demand health care. The limitations in the health sector as an institution and in its response at the time meant that survivors were unable to access services (3.8). Physical and mental health consequences could not be met. There was no policy, service delivery mechanisms or identified structure on which to develop these services within the health sector (3.8). Thus, exploring the trajectory of sexual violence in Kenya enhanced my understanding of the needs that the health sector needed to meet and provided me with ideas about how best to strategically frame my proposed work (chapter 10). For instance, I was able to draw on the shift from oppositional activism to government collaboration as an appropriate strategy within which to frame my work. In addition, understanding this trajectory further grounded my rationale on gender as a basic social division and a power structure that shapes policy and institutional responses (1.4) to sexual violence, and thus a need to ensure that this was considered in designing the study. As I reflect on my choice of methodology (chapter 4), I examined the intersections between this background, the lack of services, the poor institutional infrastructure and capacity in delivering services and chose to engage a pragmatic orientation in addressing these gaps.

Chapter 4 Methodology

4.1 Introduction to the methodology chapter

In this chapter I present the study design and methodology. Section 4.2 outlines the research question and objectives (4.2) and provides a brief rationale of the methodological approaches utilised drawing on the literature (2.9). I detail study design, processes and tools, providing an overview of the study methodology (table 4.2) and timelines (table 4.3). The rationale, methods and techniques used for each of the three objectives are outlined respectively (4.3 - 4.5). I present the limitations of the study as section 4.6. Ethical considerations and quality assurance mechanisms employed are described (4.7). Finally, I reflect on my positionality in this study exploring my location and the influences of a range of players in the research process (4.8). In conclusion (4.9), I present a conceptual framework of the study methodology.

4.2 Study design

4.2.1 Rationale of the study design

This study was designed to implement and assess the success of an intervention as a new approach to addressing the deficiencies of health sector responses to sexual violence, informed by socially located experiences in Kenya. On the basis of the literature (chapter 2) and the background information (chapter 3), it was hypothesised that the uptake of sexual violence services could be impacted on by implementation of a set of interventions for delivery of post rape care services and building the capacity of health providers to respond to the needs of sexual violence survivors. It was intended that the intervention would provide a standard of care and be acceptable to health providers. This process was informed by an understanding of the gendered perceptions of sexual violence which were taken into consideration in designing the study.

The underlying aims of this study (section 1.2) included an intention to inform and influence policy and practice through evidence, as acquired through this study. It was thus necessary to frame the study such that I remained open to emerging concepts and themes. I retained a

flexible theoretical position where emerging study results could be used to shape interventions, while learning lessons and exploring diverse sets of issues emerging in the delivery of post rape care services as they occurred in their natural setting[198,292].

The main research question and study objectives are outlined in section 1.3

In undertaking this study, I utilised a systematic approach.

- A situation analysis identified and diagnosed the problem through exploring perceptions on rape/sexual violence and priorities for post rape services (objective 1).
- Development and implementation of a set of interventions to strengthen the uptake and delivery of post rape care in the three district hospitals (objective 2).
- Documentation and assessment of the success of these interventions by describing the uptake, delivery and acceptability of services. The indicators utilised for describing delivery of services were the quality of delivery of the range of services - clinical evaluation and documentation, counselling and PEP delivery (objective 3)

I applied the different methodological approaches described in section 2.9 of the literature as follows:

Qualitative research techniques: to describe perceptions of sexual violence through focus group discussions, and priorities for sexual violence responses through key informant interviews whose methodology are captured in section 4.3 and the findings in chapter 5.

Feminist epistemologies and gender analysis: informed the data collected (4.9.3-4), gender stratified sampling strategies (4.9.3) and reporting of the findings (chapter 5). Analysis was undertaken with an understanding of existing social and institutional gender influences, with this categorisation informed by the VHA framework. The ecological model of sexual violence provided a background for exploring the causative factors. My reflexive approaches , outlined in sections 4.8, 8.6 and 9.4 were informed by feminist perspectives.

Action research principles: I used praxis primarily for meeting objective 2 of the intervention process. These included consultations with health providers (7.3), training health workers and establishing systems for delivery of services. Transformative participation aimed to strengthen district hospital capabilities to make decisions and manage post rape services, was

an underlying objective of this study and therefore the extent of participation was often negotiated with the health providers and managers. While participation of health facility managers can be framed, the levels of cooperation of different individuals within the institution cannot be measured or determined, discussed further within my reflexivity in 6.4

Quantitative techniques: provided additional utility in describing the success of the interventions through the use of descriptive statistics.

4.2.2 An overview of the study methodology

The 'boundary problem' in naturalistic inquiry is about trying to determine the extent to which it is desirable to study one or a few questions in great depth or many questions in less depth. Establishing focus and priorities is often based on trade-offs in resources, time, the potential for continuity of the study, (i.e. whether some questions can be asked and answered at a later date), the study goals and interest of participants[5]. I understood that the 'boundary problem' was also related to the broad continuum of prevention, care and rehabilitation, in the context of sexual violence. I therefore chose to focus on the 'care' aspects of this continuum of responses based on the rationale provided in my reflexivity (4.8).

Table 4.1 An overview of the study methodology

Sub objectives	Sampling	Sample Units	Sample Frame	Data Collection Methods
Objective 1: To describe perceptions of rape and identify priorities for post rape care services				
Explore perceptions on rape/sexual violence	Stratified	Adult Women Adult Men Adolescent Women Adolescent Men	5 groups 3 groups 4 groups 4 groups	FGDs
	Purposive	Commercial Sex Workers	2 groups	
		Religious Leaders	3	KI
Identify priorities for post-rape care services in Kenya	Stratified	Health Service Providers	11	KI
		Police	5	KI
		Policy Makers	4	KI
	Snow-balling	CSO		Workshop
		Counsellors	5	KI
Objective 2: To document the design and development of a strategy for post rape care services				
Consultations to develop strategy	Stratified	District Health Management Teams	3 teams	Workshop
Capacity building for health providers	Stratified & Purposive	Clinicians/lab staff	120	3-day training
		Counsellors	--	3-month training
		Health providers		3 hr training
Objective 3: To describe uptake, delivery and acceptability of post rape care services				
Describing uptake and delivery	Convenience	Presenting survivors of sexual violence	386 (295 records analysed)	Health records
Analysing acceptability	Stratified & Purposive	Health managers	14	KI
		Front line service providers	19	KI
		Records officers	3	KI

Note: All districts (cases) were represented in each of the sampling strategies as shown in the detailed methodology frames of each objective (tables 4.4; 4.5; 4.6)

Key: *FGD - Focus Group Discussions; *KI - Key Informant Interviews; *CSO - Civil Society Organisations; lab - laboratory

4.2.3 Timelines of my study

The problem identification and diagnosis phase (objective 1) was undertaken between January 2003 and July 2003. The development of a strategy (objective 2) overlapped with the implementation process was undertaken between August 2003 and July 2005. Data collection for purposes of this thesis ceased in July 2005, and post rape care services are still operational.

Table 4.2 Timescale of research activities between 2003 and 2006

	2003												2004												2005						'06
	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J D	J D
To describe perceptions on rape and establish priorities for sexual violence																															
-Training research assistants		x																													
-Field work: interviews, focus group discussion			x	X	x																										
-Data analysis					x	x																									
To design and develop a strategy for delivery of post rape care services																															
-Consultations with health management teams						x																									
-Development of registers: laboratory, casualty, clinical records and algorithms						x	X	x	X																						
-Services operational - Thika									X	X	X	x	x	x	X	x	X	X	x	X	x	x	x	x	x	x	x	x	x	x	x
-Services operational Malindi														x	X	x	X	X	x	X	x	x	x	x	x	x	x	x	x	x	x
-Services began in Rachuonyo																x	X	X	x	X	x	x	x	x	x	x	x	x	x	x	x
-Training trauma counsellors															X	x	X	X						x	x	x	x	x	x	x	x
-Algorithms revised																x															
-Clinical PEP records revised														x		x															
To describing uptake, delivery and acceptability of post rape care services																															
-Data collection											X					x	X	X	x	X	x	x	x	x	x	x	x	x	x	x	
-Data analysis																									x	x	x	x	x	x	X
-Feedback to DHMTs																										x	x	x	x	x	X
-Writing up thesis																															X
Policy engagement and influencing																															
- Engaging DRH																			X												X
- National standards																				X	x	x	X								X
- Training Curricular																						x	x	x	x	x	x	x	x	x	x
- Model for PRC services																															x

4.3 Objective 1: To explore perceptions on rape and establish priorities and post rape services in Kenya

Objective 1 was considered in two sections. The first set of research questions explore community perceptions and the second views on priorities for post rape services based on policy maker and practitioner priorities.

4.3.1 Data collected for objective 1

- *What are the community perceptions of rape in Kenya?*
- *What are the community/survivor perceived priorities for a good service?*

This objective was premised on the understanding that sexual violence is a socially constructed gender issue (1.2). Information sought drew on literature. Gender is a social and power structure that influences sexualisation (1.4.1), thus gender disaggregation in data collection and analysis were employed. Drawing on feminist theorising of sexual violence, it was necessary to understand diverse and gendered experiences, as well as socially located responses to of sexual violence (2.4; 2.6). The existence of diverse of meanings (2.4.2; 3.5) and emerging tensions of conceptualising sexual violence, including in Kenya (2.4.3; 3.4.1-2) informed my need to examine local understandings in order to determine their influences on uptake and delivery of services.

Information was sought on:

- Communities perceptions of what constitutes sexual violence, reasons for sexual violence
- Community understandings of the commonly used terms to describe sexual violence (rape and sodomy)
- Awareness of links between sexual violence and HIV
- Community mechanisms for addressing sexual violence situations
- Services available for sexual violence survivors and community understandings of procedures for access of these services
- Community attitudes towards services providers

- Propositions from communities on what could be done differently with regard to addressing the needs of sexual violence survivors

These issues informed the design of the focus group discussion guidelines (annex 4)

- What are the priorities for action by policy makers and the health sector in order to deliver a minimum standard of post rape care services?

- What are the minimum standards for a post rape care service?

A range of service providers including the police, health care and legal service providers were targeted based on the understanding that health care outcomes are connected to other aspects in the prevention, care and rehabilitation continuum (1.2). The interactions of the micro, meso and macro levels highlighted in the VHA (1.5.1) facilitated identification of the range of service providers and policy makers to be interviewed about varied services as required to address the health consequences of sexual violence. For instance, focus on the police and legal services was on medico-legal issues relevant for the health sector (2.5; 2.7) informed by concerns regarding the Kenyan legislation and protocols for legal engagement (3.6). Information sought on mechanisms, capacities and challenges for service delivery was informed by health sector policy and programming (2.8), with specificity to the Kenyan systems and structures (3.7.2) and gaps in responses to sexual violence (3.8).

Information was sought on:

- The nature of services offered by the police, in health care facilities and for legislative type support
- The procedures and legal requirements for delivery of these services
- The perceptions of service providers with regard to the functionality of systems in place, health provider ability to deliver these services,
- The constraints and challenges faced by service providers
- The capacities available for delivery of services for survivors and propositions to strengthening any identified weaknesses
- The priorities of health care service providers in providing care for survivors of sexual violence

These tools are provided as annex 5

4.3.2 Start-up and selection of study sites

In October 2002, I spent the first month understanding LVCT and the strategies used for VCT intervention. I undertook a three week training course as a VCT counsellor. I attended a two day workshop on PEP for sexual assault in medical settings in South Africa and at the same time visited several rape crisis centres both in Cape Town and Johannesburg as part of background information. I also did a background search on the trajectory of sexual violence in Kenya. The problem identification and diagnosis phase was informed by this understanding (3.4).

Three sites were identified as study areas based on the existence of established VCT sites that have been functional for over a year. The rationale was guided by the need to have functional HIV counselling and testing services, as a necessary part of PEP provision. The selection of districts further took into consideration the need to reflect geographical, religious and social diversities so that perceptions captured were from heterogeneous groups in Kenya (3.10). The three districts selected for this phase included Nairobi, Thika and Malindi.

A team of 10 research assistants was recruited from among VCT counsellors in Liverpool VCT and Care and trained for 1 week in qualitative research methods. VCT counsellors were selected for their understanding of, and skill in, handling sensitive issues and situations. Their understanding of the need to practice confidentiality was an asset for the study and the training and subsequent research conformed to WHO ethical and safety recommendations for domestic violence research[211] .

Dr. Sassy Molynuex, an experienced social scientist provided guidance and led the 6-day intensive training programme. The study design was discussed in detail with the research assistants who provided their input. Emphasis was on the information needed to address the objectives, sampling techniques and data collection tools. Processes to enhance the quality, reliability and validity of data collected were critical. Consensus was reached on roles and responsibilities of the teams, their place as researchers vis-a-vis as counsellors in consideration of ethical concerns arising from the study and expectations of the teams and principle researcher. As part of the training take home assignments and readings, individual and

group exercises were given. During the training, participants were asked to identify the most commonly used words in reference to sexual violence in its variant forms through informal discussions, media reports and other grey literature. The terms 'rape' and 'sodomy' were identified as those commonly used and widely known in the public domain and this informed the design of study tools.

Etiquette of the research teams and protocols for group discussions and interviews were set. At the end of the course each research assistant was provided with a course manual on qualitative research methods, an easy-to-read handbook on qualitative methods[293] for reference and a practical field manual as a handbook and guide during their field work. Exercises to practice data collection, feedback and debriefing were undertaken in groups of three for 2 hours each day. Each research assistant was certified for attendance of the course. A certificate was presented at the end of data collection to show practice in the use of methods.

4.3.3 Data collection methods for objective 1

Non probability sampling was used through out the study. The aim was to be theoretically representative of the study population, maximise on the range of variation in information collected[294]. Participants represented the range of variation on those characteristics that seemed meaningful to the topic under study. Non-probability samples are based on purpose and rationale rather than size, with inherent flexibility that allows for optimal information[295].

Stratified sampling allows selection of participants from sub-groups of interest to illustrate the characteristics of the subgroup and thus facilitate comparisons within and without the subgroup[295]. Stratified sampling was used for two purposes, to identify community groups by study sites and to identify service delivery institutions. Community groups were sampled through existing recognized social structures, the Department of Social Services, the Ministry of Health, NGO/Service providers in each of the sites. Participants comprised community members resident within the vicinity of VCT sites, conveniently selected to reflect potential users. Gender and age disaggregation was informed by feminist perspectives[296]. Due to the diversity of participants in the selected community (Ziwani) in Nairobi, women living with HIV/AIDS were interviewed as an additional group. Service delivery institutions including

private and public hospitals, VCT sites, police stations in each of the study sites were selected. In addition, purposive sampling ensured that study participants ranged from persons at managerial positions to front-line service delivery staff.

The logic and power of purposive sampling is in selecting information rich cases for in-depth study and these may be groups or individuals. These may be due to their deviation or intensity thus learning from highly unusual manifestation of the phenomena under study[294,295]. Key informants are those individuals who are presumed to be knowledgeable on a situation or issue by virtue of their occupation, socio-economic, education and power (however it may be conceived) status, or experience in the given context. Key informant interviews therefore tap into 'rich' sources of knowledge allowing an intense manifestation of the phenomena under study[294]. Interaction in the interview process requires researcher feedback to communicate presence and understanding of these meanings. It is essential that the researcher understands their purpose, asks the right question and provides feedback, without giving their opinions within the interview process[294,297,297,298]. These could potentially bias the interview by imposing researcher structure and assumptions. Purposive sampling was used in selection of a group of commercial sex workers from each study site and in selection of key informants for in-depth interviews. In selecting sex workers, it was difficult to establish contacts in Nairobi as it required the mediation of research institutions already working with these groups. In addition, participants requested payment for participation in the study and thus were not interviewed.

Focus groups are a qualitative and inductive approach to data collection. They bring together six to twelve people with some homogeneity but do not exist as an a priori group. Participant discussion about perspectives, views, thoughts on an issue is the intent[299]. Homogeneity is determined by the study purpose and requires an understanding of the influences on group dynamics including age, gender and socio-economic status in the particular setting[300,299]. Groups allow for exploration of social processes in the articulation of knowledge including what is censured, and by whom in a group[300]. Good interview/moderation skills are however necessary in order to capture occurrences and avoid reinforcing group ideas[301].

Snowballing, an approach for locating information rich units of analysis, or critical cases was used[294]. One of the cases of interest from amongst the units of analysis identified was to give recommendations about other knowledgeable units of analysis and a snowball develops. The chain length (number of units) is determined by information considerations so that sampling is only terminated when no new information is forthcoming from new sampled units, when the point of redundancy or saturation is reached[199].

4.3.4 Sample selection

To establish perceptions of sexual violence, sixteen focus group discussions included one group for each category; adult women, adolescent women, adolescent men and adult men in Thika and Malindi and two of each category in Nairobi, with the exception of adult women who had an additional third group of women living with HIV/AIDS. Two focus group discussions with commercial sex workers were conducted in Thika and Malindi each. Five religious leaders interviewed were from Thika (one Catholic and one Protestant), Malindi (2 Muslim), and Nairobi (one Protestant), from within the vicinity of the selected VCT sites. Table 4.3 below reflects participant selection.

To establish priorities for post rape care services, snow balling was used to identify organizations providing services. From informal discussions with a policy maker from the Division of Reproductive Health, a medical officer working at the Nairobi Women's Gender Violence Recovery Centre, and a programme officer at the FIDA, I began a snowball of respondents involved in addressing sexual violence. 40 key informants were targeted. A point of saturation where no new themes were emerging and information collected became repetitive, was reached at 34 key informant interviews thus snowballing was terminated.

Thirty-four individual key informants (19 female and 15 male) did individual interviews. Thirteen participants (ten clinicians, two laboratory technician and one administrator) represented health care facilities; four counsellors from VCT sites, six from religious institutions, six from advocacy and legal organizations and five police officers.

In March 21st-23rd 2003, I was invited to a workshop on 'forensic medical examination, care and treatment of rape survivors in Kenya' held at Naro Moru by Amnesty International

Kenya. The workshop had 56 participants, representative of legal, advocacy, health services, counselling, care and rehabilitation, civil society organizations, 4 government departments from across the country (7). I also used this as a source of information.

Table 4.3 Study participants for establishing community perceptions on sexual violence

Sample units	Sample area	Sample frame (area and number of participants per group)	Date of FGD
Adult women	Nairobi	-11women living with HIV/AIDS different parts of Nairobi -12 Single mothers from Ziwani - 10 participants from Kawangware	17/3/03 14/3/03 15/3/03
	Thika	- 11 participants - Thika town	28/2/03
	Malindi	- 8 participants – Kakuyni	26/3/03
Adult men	Nairobi	- 7 participants- Kawangware	7/3/03
	Thika	- 9 participants – Thika town	20/3/03
	Malindi	- 9 participants – Bahari	28/3/03
Adolescent women	Nairobi	- 7 participants – Mathare - 13 participants – Eastleigh	5/3/03 6/3/03
	Thika	- 9 participants – Gatundu	4/3/03
	Malindi	- 8 participants- Malindi town and environs	12/3/03
Adolescent men	Nairobi	- 12 participants – Mathare - 11 participants – Riruta	5/3/03 10/3/03
	Thika	- 14 participants – Thika town	7/3/03
	Malindi	- 10 participants – Environs of Malindi town	28/3/03
Commercial sex workers	Thika Malindi	-Thika town – interview held at Redcross hall - Malindi town – interview held at Solwodi hall	12/3/03 19/3/03
Religious leaders	Nairobi	-Ziwani (one Protestant)	7/3/03
	Thika	-Thika Town (one Catholic) -Gatundu (one Protestant)	10/3/03 27/2/03
	Malindi	-Bahari & Malinidi town(two Muslim)	6/3/2003

[7] A medico-legal network on gender based violence in Kenya was created from this workshop and has been working towards development of a strategy on addressing sexual violence and post-rape care services in Kenya

Table 4.4 Study participants for identifying the priorities for post rape care services in Kenya

Sample units	Sample frame (study area and number of participants)				Data collection methods
	Nairobi	Thika	Malindi		
Health service providers (health facilities)	4 (3F,1M)	2 (1)	3 (1 public, 2 private)	Stratified	KI interviews
VCT counsellors	2 (2F, 1M)	1 (F)	2 (1F,1M)	Purposive	KI interviews
Police stations	4 (M) (officers in different stations)	Did not get consent for interviews	1 (M) (police station)	Stratified	
Civil Society organisation involved in GBV interventions	Legal services, advocacy, religious institutions,			Snowballing	KI interviews Workshop participation
Policy makers	Health sector (2F), criminal justice (1M), research institution (1F)			Stratified	KI interviews

4.3.5 Data analysis for objective 1

The research assistants were divided into 3 teams, each with a team leader. The teams undertook a 4 day mobilization exercise from February 24th - 27th in Nairobi and Thika Districts and from March 3rd to 6th in Malindi. Mobilization included: identification of sample populations, discussions with 'gatekeepers' (8) to arrange for interviews and discussion and putting logistics in place to collect data. Data collected was then submitted entered into a data submission form for entry and analysis. Daily review meetings were held by teams and included literal transcriptions of data collected. Data entry was done based on the original transcriptions produced by the research teams. I met weekly with each team to support the process and address process or logistical issues arising. I also kept a logbook for entry of methodological decisions made and changes in the planning framework, on interviews undertaken and the ways in which snowballing was used as a sampling technique. Throughout this phase of the study, analysis was carried out on an ongoing basis. Immediate

[8]These include people in charge of groups or institutions (formally or informally) and are therefore central to communication with members of these groups/organizations or institutions. For instance, the coordinators of youth groups, managers of institutions from which respondents were sought

debriefing exercises of all focus group discussions were undertaken and the understanding of key terms and perceptions discussed. Transcription was done as soon as possible after the interview.

I undertook content analysis with support from the team leaders. This was done through identifying the key themes emerging from the research. I read through all of the transcriptions, drawing out initial key themes and then sorting and labelling the entire data set with these themes[302]. Focus group discussions from each of the districts were analysed first in order to allow for adjustment of tools to capture new data. Sub-themes were also developed within these key themes. I then summarised the data, identifying key elements, defining categories and established typologies[294,303]. 6 key themes emerged from the data on perceptions of sexual violence (5.1). Key themes were drawn and triangulation of these undertaken through comparing and contrasting data from the different districts and the different groups interviewed (gender and age). Triangulation aided analysis through comparing and contrasting main points emerging from different participants (counsellors, health providers, stakeholders from organizations, government), different research sites (districts), different research methodologies (focus groups, interviews, reports etc)[304,305]. This allowed me to portray meanings of data collected, refine and distil concepts[306]. I was therefore able to develop a standard of care, and the requirements for support systems necessary to deliver the standard of care. This was however, not a linear process, but with overlaps.

Verifying conclusions involved drawing meaning from sets of data by noting patterns, themes, making contrasts and reaching conclusions. A summary of the study processes highlighting emerging themes as perceived by each research team was written and presented at the end of the data collection process. It also included the teams' issues around logistics of the study and pertinent issues for LVCT as an organisation. Dr. Sassy Molyneux provided additional independent data analysis.

4.4 Objective 2: to document the design and implementation of a strategy for the delivery of post rape care services in 3 district hospitals

4.4.1 The set of interventions

The process of implementation was premised on the principles of co-generative inquiry where knowledge and experience of participants were key hence the extensive consultations. Participation was aimed at empowerment of health providers and transformation of the systems (2.9) within the health facilities in order to institutionalise post rape care services. The key steps in the intervention strategy included:

- Consultations with DHMTs including development of service delivery algorithms
- Capacity building/training activities
- On-going consultative activities and monitoring

4.4.2 Selection of study sites

Data from objective 1 informed the development of objective 2 as described in chapter 6. The problem identification and diagnosis was undertaken in Nairobi, Thika and Malindi. For intervention purposes however, the District Rachuonyo, replaced Nairobi. At the Nairobi Women's Hospital Gender Violence Recovery Centre was offering services to Nairobi (3.8). In addition, discussions with a policy maker from the DRH and counsellors at LVCT cited the need to incorporate a rural district. There were also requests from the Rachuonyo District DHMT to provide post rape care services. Criteria used to identify the sites was presence of established VCT sites that had been functional for over a year with supervision structures in the district hospital, availability of practicing support supervision counsellors. Selection took into consideration differences in the health facilities - client flow, the number of staff, the catchments' population and interest to be a study site, as discussed with the Medical Officer of the Health facility at the time. Rachuonyo district hospital had the added advantage of a different size of health facility in relation to Malindi and Thika (3.11)

4.4.3 The implementation strategy for the interventions

Consultations with District Health Management Teams: Discussions were initiated with the District Medical Officers of Health in each district, who were made aware of this process as a study. The results of the exploratory study were presented to the DHMTs. A workshop was undertaken for DHMT members in June 2003 from the three districts with objectives to:

- Raise awareness of sexual violence, its intersections with gender and implications for services delivery
- Provide up to date information on the medical management of sexual violence survivors
- Develop a consensus on the roles and responsibility, and mechanisms for services delivery in each health facility.

The underlying aims of this workshop were to develop a sense of ownership for post rape care services delivery, and explore the expectations of the DHMTs and LVCT. The training programme was participatory and content based on the ecological model of (gender based) violence and the VHA framework. Drawing on the ecological model, participants discussed the inter-relationships between the hierarchical levels and the identified causal factors of sexual violence in their contexts as individuals, community members, and institution managers. They analysed the implications of each of these factors focussing on the Kenyan situation. The VHA framework was applied in participants' exploration of the existing responses to sexual violence at micro, micro/meso and meso/macro levels. In this exploration, the complementary nature of both frameworks was utilised. Micro-level responses were related to individual causal factors, micro/meso to community related causal factors and, meso/macro to institutional level factors. The implications of current responses and desirable responses to sexual violence discussed with a focus on the health sector.

Development of service delivery algorithms: Information was provided on the consequences of sexual violence and thus, the range of post rape care services required (2.5). Client flow pathways for each health facility were discussed in cognisance of varied geographical layouts of each health facility. Processes to enhance the quality and reliability of services such as on-going consultations and technical assistance by LVCT were discussed.

Service delivery points and their respective data and recording needs were identified and tools developed, as follows:

- Registers for casualty and laboratory points of service delivery
- Routine clinical records for PEP management that doubled up as data records

A simple post rape care algorithm (figure 6.1) was developed and the appropriate service delivery points identified. Considerations made in developing the algorithm are described as part of chapter 6. Wall charts and flow diagrams were developed as job aids and placed in the various service delivery points. Training needs for health staff at casualty, the HIV care clinic, laboratories and for counsellors were identified and it was agreed that LVCT design and support provision of these. Implementation began at Thika district hospital in October 2003, at Malindi district hospital in February 2004, and at Rachuonyo district hospital in April 2004. The five month difference between Thika and Malindi was due to the holiday month of December when activity at both the district hospital and LVCT slows as people prepare for holidays and staff take-up annual leave.

Designing health provider training programmes: These were based on three issues: *What needs to be learnt? How best can learning be undertaken? Can this be delivered, and what are the practical implications?* In attempting to answer these questions the need for two broad learning approaches emerged; information and skills on medical care for sexual violence survivors and legal aspects of sexual violence, and change of attitudes through gender training. With regard to the practical implications, there were logistical issues of staff shortages, the availability of staff in relation to time required/spent in training and DHMT rationale on capacity requirements. With these considerations two distinct training programmes were designed in August 2003, aimed at:

- Medical and clinical officers, nurses and laboratory staff
- Counsellors
- In March 2004, an additional training was designed to orient all staff in the hospital.

Training designs were premised on best-practice and ethical principles when working with survivors emphasizing the primacy of confidentiality and respect for choices made by the survivor[307]. In the two programmes designed in 2003, health workers were supported in confronting the underlying myths and beliefs that concern sexual violence (6.3). Service provider biases, prejudices and fears regarding sexual violence were explored. This resonates with concerns raised in literature (2.7.3) about sexual violence training programmes that highlights the need to examine service provider attitudes and beliefs about gender, power, abuse and sexuality. A focus on clinical management and counselling was offered as was appropriate for each group.

Training for trauma counsellors following sexual violence was informed by community perspectives from the diagnosis phase (5.2 - 5.5), literature (2.3-4; 2.6), and LVCT experiences from VCT counsellor supervision experiences. The training was designed as a three phased course spaced out over three months taking cognizance of gaps and counsellor requirements at their health facilities.

While training content was the same for all districts, there was flexibility in the target group for each of the trainings and the number of trainings held for each district. This was dependent on needs identified and discussed with the heads of departments in each relevant service delivery points and DHMTs. The process of the development of the trainings is documented in chapter 7.

Table 4.5 Health provider trainings as provided during the intervention

District	Dates of training	Target group	No. of partici pants	Type of training
Thika	October 2003	In-charges of departments for service delivery points	14	3-day training
	March 2004	Clinicians and nurses from casualty, outpatient, laboratory staff	28	3-day training
	July 2004	Clinicians, nurses and laboratory staff	36	3-day training
Malindi	March 2004	All heads of service delivery points in the hospital	12	3-day training
	August 2004	All clinicians, nurses, laboratory staff	21	3-day training
	November 2004	All health providers orientation on post rape care services	60	3 hr orientation course
Rachuonyo	May 2004	All clinical officers and heads of departments	9	3-day course
	August 2004	Clinicians, nurses from casualty, outpatient, laboratory staff	23	3 hr orientation course
	March 2005	Health providers orientation		3 hour course
Thika, Malindi, Rachuonyo	--	VCT counsellors for Rape Trauma Counselling Course		3 month course

On-going consultative activities and monitoring of the intervention: Trained health providers delivered services to survivors of sexual violence in each of the health facilities. Tools used for data collection at the different points of health facility are described in section 4.5.

- Consultations every quarter with heads of department in each service delivery point in each hospital. These included feedback on key concerns emerging from the monitoring visits in service provision and from staff, challenges and potential solutions. A review of the decisions arrived at the last meeting was undertaken. These meetings were informal and were undertaken at any point that the researcher could access the head of department
- Consultations with health providers at service delivery points. These were ongoing with at least a monthly visit to each hospital. Issues discussed included key challenges, barriers to services provision, what could be improved, how and who should be responsible

- Monitoring service delivery points to ensure registers, drugs, care consumables are available at agreed points and in use monthly
- Monitoring client information and data recording in the HIV care clinic at least every two months

4.5 Objective 3: To describe uptake, delivery and acceptability of post-rape care in 3 district hospitals

In assessing the successes of the intervention I described the uptake, delivery and acceptability of post rape care services. Indicators used to describe uptake and delivery were coverage, quality of service - clinical management, counselling and PEP delivery. These indicators utilised quantitative data collected through the implementation process at various points of services delivery. Acceptability was described utilising data collected at 9 months of the implementation process.

4.5.1 Data collected for objective 3

Data for analysing uptake and delivery of post rape care services were collected as part of routine clinical data as agreed during consultative meetings with DHMTs and health providers during the development of the intervention (6.2). Routine clinical data collected at each service delivery point included data on:

- **The casualty record** reported data on survivors name, date and time of presentation, age, sex, date and time of assault, the examining officer, the number of perpetrators, self reported sites of penetration, physical examination taken, presentation <72 hours to evaluate eligibility for PEP and EC where applicable, EC delivery, reasons for not offering EC, start PEP dose administration, physical examination, reporting to police, survivor referral to counselling, to STI treatment and to the HIV care clinic (annex 6)
- **The laboratory register** reported data on: date and time of presentation at the laboratory, survivors name, a lab number, tests undertaken, results for each test, signature of laboratory technician, signature of police officer picking specimen/results (annex 7)
- **The HIV care clinic record** included the following: survivor name, date and time of presentation, age, sex, injury to dose time, presentation <72 hours to evaluate eligibility for PEP and EC where applicable, point of presentation, delivery of STI prophylaxis,

laboratory PEP related tests (SGPT/ALT, Creatinine and/or hb), counselling delivered, HIV test results, PEP (dis)continuation, symptom/side effects, number of PEP completion days, return for counselling at 2, 4, 6 weeks and 3 months, return for clinical evaluation and return for follow-up HIV testing at 4-6 weeks (annex 8)

- **Pharmacy records** included the following: date, survivor name, age, sex, drugs prescribed and drugs dispensed

Data for describing acceptability were collected primarily from service providers to assess their perceptions of the intervention (2.8.3; 4.5). The following information was collected.

- Awareness of post rape care services in their institutions
- Perceptions of these services and their relevance for the health facility
- Awareness of the nature of services, procedures for services delivery provided in the health facility especially those located in relevant service delivery points
- Understanding of referral systems
- Perceptions on training and additional required capacities to deliver services
- Perceptions on added-value by the services
- Challenges and constraints in the delivery of services
- Options for improvement of services

Two tools were developed. One aimed at capturing perceptions of health managers and the second tool aimed to capture information from front-line service providers (annex 10). The tool aimed at managers captured additional issues of responsibility for services coordination and delivery, record keeping information and overall capacity requirements. Information on the actual mechanisms and requirements for specific services at varying delivery points was gathered from front-line staff.

4.5.2 Sampling and data collection for objective 3

To describe uptake and delivery of post rape care services I developed a data form (annex 9) for purposes of collating data gathered from the various service delivery points. The form was designed based on an understanding that we were not testing the post rape care service rather assessing the success of the interventions. It is the findings of these collated data that are presented in chapter 7.

In describing the uptake of post rape care services, I sought to summarise the characteristics of the survivors taking up post rape care services utilising demographic, rape and survivor presentation characteristics.

In describing the delivery of post rape care services, I sought to assess the proportion of presenting survivors who received the standard of care (all services in all service delivery points) and as recommended in the referral pathway described in 4.5.2 and Fig 6.1. PEP delivery was also described. These included:

i. ***Coverage:*** For each survivor, data was extracted from routine clinical records and collated on the data form as discussed above. The summary of survivors who accessed the various services, and received care were described.

ii. ***Quality of examination and clinical management:*** The numbers and profiles of eligible survivors initiating PEP, STI treatment, emergency contraception and receiving examination and documentation at the point of presentation

iii. ***Quality of counselling:*** The numbers and profiles of eligible survivors initiating counselling for trauma, HIV pre and post test, PEP adherence and preparation for the Justice system at the VCT service, receiving HIV testing at presentation and retained for counselling during the PEP treatment period

iv. ***Quality of PEP delivery:*** The numbers and profiles of eligible survivors initiating, continuing and completing HIV PEP, retaining for PEP mediation (including recommended follow up at 2 weeks) and HIV testing at 6 weeks

To describe acceptability of services, I utilised stratified sampling to sample participants from each health facility and held individual interviews with varied cadres of health providers including nurses, clinicians in casualty, laboratory staff and counsellors. Table 4.6provides an overview of the participants in describing acceptability of post rape care services. Front-line staff were interviewed from each health facility as shown in table4.6. Four medical officers one from Malindi and Thika each, with two from Thika district were interviewed as both health managers and as service providers due to their dual roles. The additional interviewee in Thika was a private medical practitioner who was identified by a medical officer at the

study site, as referring survivors to the health facility. It could not be established exactly how many survivors were referred.

Table 4.6 Study participants in describing acceptability of post rape care services

Sampling units	Thika	Malindi	Rachuonyo
Health managers			
Medical officers	3 (2 M & 1 F)	1 (F)	1 (M)
Casualty in charges	1 (F)	1 (F)	1 (M)
DASCOs	1 (F)	1 (F)	1 (M)
Nursing officers in charge of health facilities	1 (F)	1 (F)	1 (M)
Front line service providers			
Clinical officers	2 (F)	1 (1F; 1M)	1 (M)
Laboratory technicians	1 (M)	1 (M)	1 (M)
Pharmacists	1 (M)	1 (M)	1 (M)
VCT counsellor supervisors	1 (F)	1 (F)	1 (F)
Trauma counsellors	1 (F)	1 (F)	1 (F)
Nursing officers in the female wards	1 (F)	1 (F)	1 (F)
Records officers	1 (M)	1 (F)	1 (M)

4.5.3 Data analysis for objective 3

To analyse data on uptake and delivery of services, data from the collated form (annex 9) were entered and analysed using Epi Info 2000. Information was anonymised through a system of client coding and all confidential materials, including casualty registers and data collection forms were stored in locked cupboards to which only the immediate service providers and I had access to. To describe characteristics for uptake and delivery of services, I applied uni-variate analysis to the study population. The distribution of all continuous data from this data set were skewed, hence I applied non-parametric tests. I applied descriptive statistics of proportions for categorical data.

To analyse data on acceptability of services I chose to use the 'framework' analytical approach, over content analysis based on additional literature during the time of the study. I felt that the use of a cross-sectional application of index provided increased transparency in the analysis process. Its strength is in its use of comparative matrices that enable (1)

comparisons across different sites and between the views and priorities of different stakeholders and (2) different people from different perspectives and positions can participate in this process. Its potential to be mechanistic has been identified as a key weakness. This was countered through being open to new discoveries and themes emerging in the data and maintaining an inductive approach[308].

Stage 1: Familiarisation - transcripts were all read and a list of themes developed.

Stage 2: Developing a thematic framework. Findings resulted in 16 key themes that were organised based on issues raised in the interview guides for service delivery providers. These included awareness of PRC services at health facility, awareness of management protocols, awareness of links between HIV/AIDS and rape, perceptions on the benefits, challenges and opportunities for post rape care services, institutional capacity and coordination of services. Findings from front-line staff at various service delivery points included themes from additional details such as knowledge of HIV/PEP, required investigations, understanding of referral systems. Additional themes emerging from the findings relate to access issues, and concerns raised about survivors and about perpetrators.

Stage 3: Coding or indexing - numeric variables were assigned to each theme and sub-themes by the research team. I took a random selection of 7 transcripts and cross-checked them against the final thematic framework, and indexes as a quality assurance measure.

Stage 4: Charting – the indexes were applied cross-sectionally across all the data, so that on each transcript a list of codes ran along the right hand side of the page. On the left hand side, any issues considered important, unclear or could be used to illustrate key points were outlined. Trustworthiness was increased by ensuring that familiarisation and charting of each transcripts was done by different persons in the team.

Stage 5: Mapping – a matrix that indicated all the sub-themes along the row and informants along the column was filled up with information emerging from each respondent. Mapping was undertaken by myself with support from two research assistants from the team. I undertook the final process of interpretation of the data.

4.6 Study limitations

The lack of baseline data on post rape care services or survivors of sexual violence at the beginning of this study limited the extent to which I could assess the success of the intervention. For instance, I was unable to assess the relative increase in numbers of survivors taking up services as a result of the study.

In exploring perceptions of communities on sexual violence, sexual violence against children were not explicitly explored. Thus, findings on high numbers of children presenting for post rape care services were not analysed within a context of perceptions in Kenya, but were based on literature (2.4) and from the Kenyan context (chapter 3).

The intervention process was specific to each of the district hospitals and thus the results of this study can only support inferences about setting up post rape care services in other health facilities.

The development and implementation of the set of interventions for delivery of post rape care services was focused on the health sector and did not include the community, despite data from objective one that showed a need for community level responses. Thus, the uptake data provided was a skewed picture based on health facility data only.

The development of tools to collect service delivery data were based on consultations with DHMTs during the intervention phase of the study. Given the need to develop tools that would be applicable for actual service delivery, rather than targeted at primarily research purposes the quality of data captured in this study was compromised.

- Incomplete records and data limited descriptive analysis in this study. Data collection and entry were done as part of routine service delivery tools at the health facility. The challenges of staff workloads and documentation that characterise health systems in resource constrained settings (2.8.1), including Kenya (3.8.3) may be attributed to the poor data collected.
- Data were not collected at the counselling for trauma and HIV testing. I attribute this to limited capacity in measuring psychosocial aspects of trauma after rape that was

available at the time. In addition, the lack of a counselling structure within the MoH meant that data developed here would not be assimilated or utilised by the health facility other than for purposes of this research. Thus, during the study design, data on access to counselling was collected at the HIV care clinic where HIV test results were presented (after counselling and testing) and where return clients accessed PEP medication at subsequent visits. This may be attributed to the lack of data for describing retention of clients for counselling after the PEP period.

- Staging of the intervention process was not accompanied by staging of the assessment process, thus Rachuonyo & Malindi had experienced a shorter time of service delivery. This may rationalise the few records available documented in 7.2.
- To describe rape characteristics, Q 15 (annex 9) tried to distinguish between assailants known by those related by blood or not. This proved problematic as it was not routine data captured and thus analysis combined these two variables.

4.7 Ethical considerations and quality assurance measures for this study

Ethical consent was granted for this study in two phases and from two institutions 1) during the problem identification and diagnosis and, 2) for the intervention phase. A first proposal was submitted to the Kenyatta National Hospital Ethical Review Committee on January 9th, 2003. The proposal was referred back with requests to clarify the study rationale and expand the research background and references. The re-submitted proposal was approved. The second proposal was submitted to the same committee on October 14th 2003. It was referred back with requests for results of the exploratory phase of the study that were subsequently sent to the review board and ethical approval given. Additional ethics approval was sought and granted by the research Ethics Committee at the Liverpool School of Tropical Medicine in April 2004.

Strategies were employed through the study process to enhance ethical conduct:

- Ethical approval acquired for the study from Ethical Review Boards at the Liverpool School of Tropical Medicine and at the Kenyatta National Hospital in Kenya.
- Informed personal consent of study participants was sought at the beginning of each discussion. Participants and respondents were informed of their right not to answer any

of the questions (annex 11, 12 for informed consent forms for focus group discussions, and for interviews with survivors of sexual violence)

- VCT counsellors with skills and experience in handling sensitive issues and situations were used as research assistants for interviews and group discussions. Where respondents may have related to issues of sexual violence, VCT counsellors were able to use their counselling skills to deal with the issues and have a clear understanding and experience with confidentiality requirements.
- Interviews with sexual violence survivors were undertaken by research assistants who were counsellors, were trained through the trauma counselling programme developed, and had been practicing for at least a year prior to this phase of the research project. They also underwent a 2-day training programme focusing on ethics of interviews for survivors[211].
- Confidentiality was ensured through the study process: names of participants were only taken at the end of the training and this was specifically for purposes of accounting for transport reimbursements and records were submitted to the research officer. Data was made accessible to those involved in analysis only.
- Transport was reimbursed to participants who travelled to attend the discussions
- A drink (tea or soft drink) was provided to participants at the end of the session.
- A voucher for free access to VCT services at any of the LVCT supported sites was given at the end of the discussions to each participant. Additional vouchers were also given out to participants who requested them for partners, etc. Participants were not informed in advance of the vouchers or the soft drink.

Mechanisms to minimize potential biases included: development of a protocol for introductions, agreement on the proposed time and content of the session between the researcher and participants and training of research assistants in research methods including communication skills. Immediate debriefing and transcription of discussions and interviews enhanced study dependability by enabling the range of perspectives and understanding to be captured, and by keeping research teams aware of emerging gaps and biases. Group discussion facilitators conducted the analysis. Further independent data analysis and triangulation of the issues raised by research participants served to reduce uncertainty and biases, cross-check information and increase the range of perspectives considered.

4.8 My location as the researcher

4.8.1 Theoretical tensions on reflexivity

Gillain (1997)[134] makes problematic the concept of reflexivity because of the assumptions that are made about power and consciousness. Power can be mapped as a relationship of space or distance to the participants and process or as a relationship of sameness of both participant and researcher. Gillian (1997)[134] suggests that both positions replicate and reinforce gendered constructions of identity and power. England (1994)[309] draws on a concept of 'betweenness' that deals with understanding how difference between researchers and participants occurs and in what ways it destabilises the research process. McDowell (1992)[310] sees these spaces as blurred as they are constantly changing and being re-negotiated. In this view, research is a process where social identity of researcher and participant are continuously reproduced and negotiated[206]. Hence, *"we are made through our research as much as we make our knowledge"*(p316)[134]. It is with the understanding that I was part of this performative process of interactions and that knowledge production is complex, uncertain and incomplete that I attempt to locate myself in this process.

4.8.2 The concept of gender in Kenya

My position as an African gender advocate was important in my interactions with the district hospital staff, my interpretations of the research process, findings and the meanings I draw out of these. Having been involved in the gender and development discourse at policy and district levels in Kenya, I was aware of this positioning prior to beginning the project. Addressing gender issues is viewed as a culturally inappropriate, a perception that I encountered in my work as a trainer on gender issues at district level (prior to this study) from both professionals and communities. It has also been viewed as *"donor driven concept with no links to reality* (p157)[311] (and described as *"a new fight for women against men"*(p157) [312] (original in italics). This view of gender expressed at community levels was also visible at national level, through political statements and resistances to the women's movements described in the background (3.4.1). This was however, in contradiction to what is available in government documents (3.3.1). Within the Ministry of health, sexual violence had been identified as an issue within the DRH. However, there was no plan or programme to address

this. Sexual violence was still an issue pretty much confined to civil society rights groups and in the private domain at the time of designing this study.

4.8.3 My positionality

I am a single Kenyan woman, from a middleclass socio-economic background and with a good education. My parents are well educated having achieved tertiary education. I was aware of the complexities of 'doing gender' given the existing situation described above at the beginning of this study. I chose to focus on the health sector for three primary reasons. *First,* the orientation and mandate of LVCT was health sector based and this was my institutional location. *Second,* the lessons learnt by LVCT in engaging government and de-stigmatising HIV/AIDS in Kenya could potentially be replicated. *Third,* was the highly politicised nature of HIV/AIDS, increasing resources and government commitment as well as the framework for service provision provided in VCT scale-up. These factors offered an ideal platform for engaging government, civil society and women's movement to catalyse sexual violence prevention and care efforts.

In retrospect, I was attempting to politicise a private domain issue, using the formal health sector. Various confronting choices emerged. For instance, I was inured by the activism and the nature of funding that was under a rights-based programme to explicitly address marital rape (an issue that emerged when establishing perceptions on rape - chapter 5). However, there emerged challenges for getting health sector ownership on this issue. This particular challenge resonates with Fine's (1994)[313]' concern that 'we' ask for others to reveal their concerns. Researchers then weigh what works for them, and adopt that leaving informants with the burden of representations. Researchers, then hide behind alleged neutrality in the choices that that they make in representing informants.

In undertaking this research, I also inserted myself into an academic discourse that identifies the health sector as an area in which to study sexual violence. This seemingly creates legitimacy for the very sector implicated for insensitivity in service provision, and whose gendered construction and application of medical knowledge and service delivery undermines women's experiences (2.7; 2.9). I was applying the concept of strategic framing, as a means to mainstream gender in the health sector by interrogating and strategically

aiming to influence this highly gendered sector. These understandings influenced my choice of qualitative methodology and conceptual framing of this study, where I sought to understand the place of the women's movements and potential implications for post rape services.

In interacting with health staff, I primarily tried to build on our commonalities and tried to minimise what I thought were differences. I did not make reference to my education nor marital status unless explicitly asked. In training I used references such as "we health providers", "our system". In addition, I undertook training as a rape trauma counsellor and attended to clients for a period of one year. I often spent residential training periods at the venue of training rather than go away at the end of the day. This facilitated more intimate interactions in which I better understood the micro-politics of the health care institutions. Hence, I was better placed to determine certain aspects of the implementation that are site specific. For instance, who (informally) was key to implementation, how best to initiate solutions that could potentially be resisted at the hospital. I focused on participatory discussions about what could be done to address challenges. This flexibility, I believe enhanced acceptability in varied settings. I also experienced a sense of great support for the project, as it was seen to be addressing an extremely sensitive concern. This was often noted by female health providers, possibly because counsellors and nurses were women. However, it did raise my interest in understanding male health provider perceptions on sexual violence and I deliberately sought a minimum of a third of men for purposively sampled interviews in hospitals in phase 3. While some of these issues cannot be wholly captured in the methodology or analysis, they were not irrelevant and are explored in chapter 8.

I did not disclose to participants, except for the District Medical Officers of Health that this study was a basis for my PhD. I was uncertain of the effects. Would this highlight the variations in socio-economic and education status, in a context where health workers were poorly trained and often de-motivated? Would this project be considered 'personal', rather than a programme with a long-term aim to institutionalise post rape services within MoH? I am still unclear and struggle with the ethical implications of this stance, even as I write this thesis. Health providers during training often raised the issue of additional monetary incentives. In line with LVCT policy of direct non-monetary support to individual health

providers this was declined. My position as an LVCT employee was undoubtedly important in my interactions with the health facilities. LVCT support to these districts had established a working relationship that allowed me immediate access to health managers, hospital records (with ethical consent of the national body), and to service providers. Given the symmetrical power relations in the government health system, (annex 2) permission for implementation by health managers to a certain extent meant acceptance of post rape care services by the service providers.

My location at LVCT was useful in establishing the health sector as the entry point. The practicality of establishing services outside of the DRH framework was found undesirable, due to the policy formulation responsibility of the DRH. This is because one of the long-term goals of the study was to facilitate evidence based policy reform and action with regard to institutionalized delivery of post rape care services in Kenya. Therefore, I began to work closely with the DRH during the second part of the study (July 2004 - December 2005). I participated in the Gender and Reproductive Health Rights Working Group and contributed significantly towards setting up a national framework for institutionalising post rape care (chapter 9). However, this was not originally framed within the study, as the extent of this interaction was not clear at the beginning. In addition, policy engagement was geared more towards possibilities of scaling up post-rape care, a future research area.

4.8.4 The location of the research teams influenced this study

The research team varied in the different phases of this study and was made up primarily of LVCT staff. They were mainly counsellors in grades of employment that were lower than that I was in and I was their trainer. Power spaces were structured from within LVCT and from my position as leader of the study. The team in the first phase of the study (4.3) consisted of six female members and five male members. Nine of the members were divided into three working teams each with both male and female represented, and were engaged with the research process for four weeks. Two persons provided administrative and logistical support. Group moderator and note-taker for each discussion/interview were self-selected amongst the group after initial observations during mobilisation. The effect, if any, of having a member of the opposite sex, sitting in gender disaggregated focus group discussions, even as silent note-takers on the interviews is unclear from the analysis of findings. In Malindi

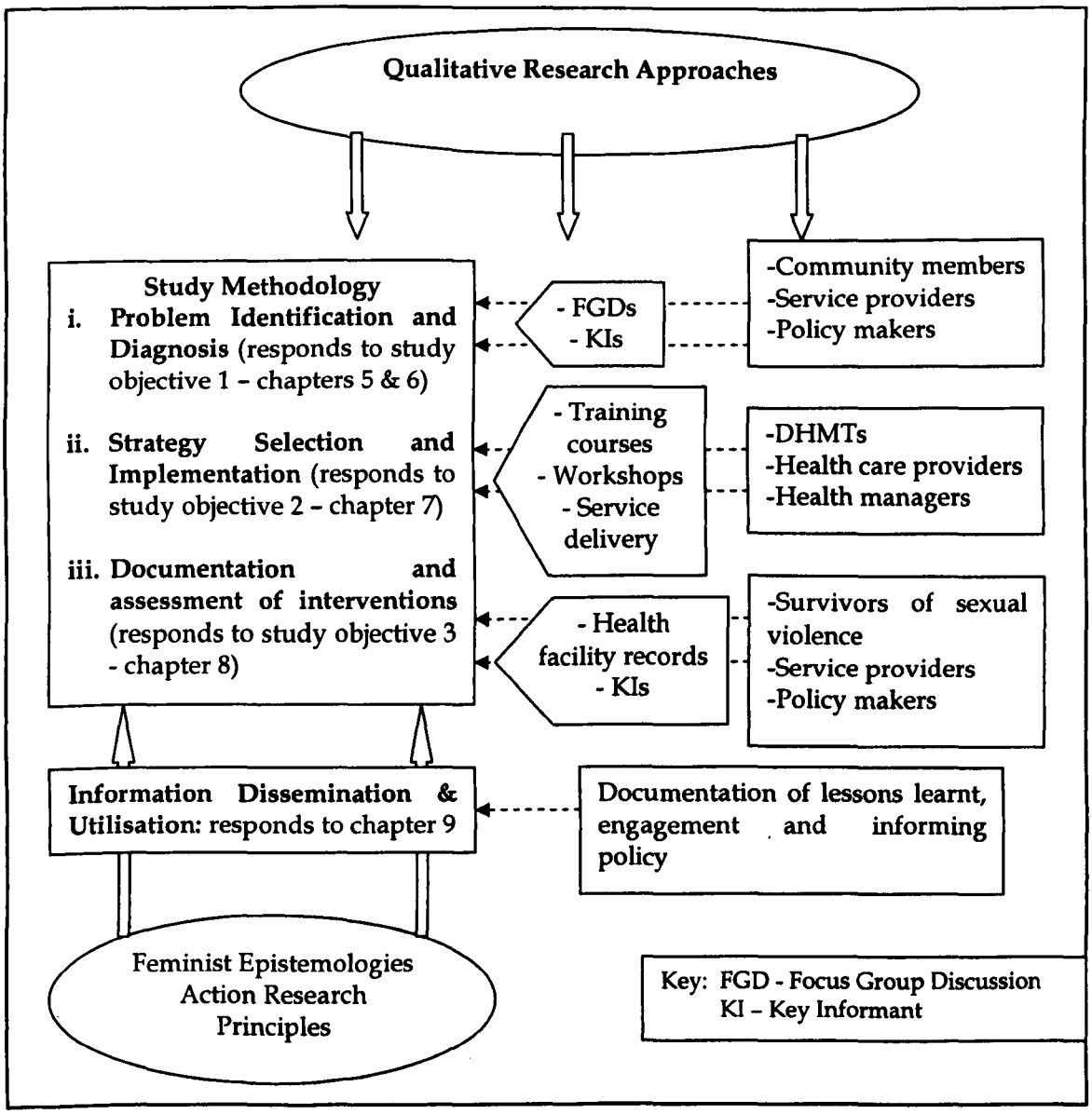
however, both female groups had both female moderator and note-taker. This was based on cultural considerations, where mixed groups draw more cultural sensitivities (3.10). I am unsure of the perceptions of health workers on the research teams as interaction was limited to interviews with select health workers. During the intervention phase of the study (4.4), I worked primarily with one female research assistant (Caroline Ajema) who also served as an administrator.

Reflecting back on the differences between myself, the research team and the health facility staff the question of power (real or perceived) cannot be overlooked. These differences were not openly discussed at formal levels. For instance, at LVCT, the extent to which the research team could apply their readings and therefore determine the direction of the intervention was limited, as my own reading took precedence as the team leader. At health facility levels, these differences were felt in certain subtle expressions such as requests by health workers to 'get them a job at LVCT', or 'intervene in transfers'. These seemed to highlight the perceived power spaces. It was hard to know what effects this unclear interaction of commonalities and variations between all involved in the research process had on us the research team, , the process and outcomes. It must however be acknowledged as constitutive to the process and a potential explanation for some limitations and successes. Through the study period, I also had increased responsibilities at LVCT and continued to work at higher policy making levels in Kenya and the International community such as the WHO. Even as I wrote up this thesis, I constantly reflected on the influence of my engagement with policy on what I did at practice level and in how far this influenced the study processes and outcomes. I was constantly confronted with fuzziness about what falls within the scope of this thesis, and which of my concomitant work did not.

4.9 Conclusion to the methodology

This chapter described in detail the methodology employed and the rationale for the methodology through out the study period. Figure 4.1 provides a conceptual map of the study methodology.

Figure 4.1 A conceptual map of the study methodology



Chapter 5 Community perceptions of sexual violence

5.1 Introduction

Findings from this chapter refer to the part of objective 1 that seeks to describe perceptions of sexual violence and are obtained from the methodology described in section 4.3. Sections 5.2 - 5.7 presents data on the perceptions of sexual violence in Kenya organised along the themes that emerged during analysis. These are local understandings of sexual violence (5.2), the perceptions and constructions of sexual violence (5.3), emerging discursive practices of sexual violence and sexual activity (5.4), and causes and justification provided for sexual violence (5.5). Discussions on awareness of care and support services by communities (5.6), precedes analysis of perceptions of constraints and challenges faced by survivors in accessing services (5.7). In section 5.8, I discuss the implications of these findings on health sector service delivery and uptake of services by survivors.

- ***What are the community perceptions of rape/sexual violence in Kenya?***

The key trigger question in focus group and key interview participants was *'what do you understand by rape?'* For the FGDs, moderators then used the emerging responses to probe further on: *whether rape/sodomy happens; to whom it happens; why it happens; and the common reactions of survivors, families and communities.* In section 4.3, the rationale for the use of the terms rape and sodomy in the study tools is described. Reporting in this chapter uses the terms rape and sodomy only as used by participants, otherwise I use the term sexual violence in order to encompass varied violations, including those not captured in the legal definitions of Kenya, as well as to differentiate my own references from those of participants.

5.2 Local understandings of sexual violence differ from legal definitions

The participants understanding of rape in Kenya, both in the community and in the health sector, differs significantly from the legal definitions referred to in section 3.6.

5.2.1 Understandings of the term 'rape'

The general consensus in all groups was that rape refers to being forced to have sex, expressed in use of terms such as *'being forced', 'without consent', 'unwilling'*. This consensual understanding was in reference to forced penetration of a vagina by a penis. What was understood to constitute force and consent (or the lack of it) seemed unclear and differed by gender and age, as explored in the sections on the context of sexual violence (5.3.4 - 5.3.6). Rape was seen to occur to women by men and was often associated with strangers - where a person is attacked by an assailant as they go about their normal business and are hurt in the process, such as when walking home from work or during a violent robbery. Two female adult groups in Malindi and Nairobi, however noted that rape is mainly done by people known to the raped person and not strangers. Insertion of other items into the vagina by use of force emerged and was cited as rape in two adult female group discussions (1 in Nairobi, 1 in Thika).

5.2.2 Understandings of the term 'sodomy'

No consensus could be established on what is referred to as sodomy. Geographical differences emerged in the use of the term. In Nairobi, sodomy was understood as consensual male sex in all three male groups and one adolescent female group. In contrast in Thika, sodomy was understood by the adolescent male group to refer to forced male sex, and there was no consensus among the male adults. In Malindi, participants from the four male groups referred to sodomy as anal sex between men regardless of whether consensual or forced. There was no consensus amongst participants in all other group discussions as to what sodomy meant.

5.2.3 Local understandings of what constitutes consensual and forced sexual activity

In all seven male groups and five of the nine female groups, discussions on sodomy and rape were interlinked with terminology used to describe various forms of sexual practices, such as men who have sex with men that was referred to as homosexuality, and lesbianism. There were differences with regard to understandings of these terminology and no patterns could be clearly distinguished from the findings. For instance, in the adult male group in Thika, where

no common understanding of the term sodomy was drawn, the following quotes are taken from the discussion.

P1 described sodomy as, *"love between two men"*

while another participant (P2) questioned,

"so, if I am gay, and have a gay partner, is that sodomy?"

and P3 did not agree, noting,

"that is homosexual. Sodomy is forcing a man..."

One female adolescent participant from Thika, had never heard about homosexuality and seemed surprised at the idea of men having sex with men.

Discussions on lesbianism emerged in all adolescent female group discussions, and one male adolescent group in Nairobi. In Thika and Malindi, forced sexual activity amongst women was identified, and no consensus could be drawn on whether it was referred to as rape or lesbianism.

An adolescent female participant from Malindi said that,

"sodomy is woman to woman, also woman to force other woman"

while another group participant noted,

"no that is lesbian"

In one adult female group in Nairobi where forced insertion of objects into the vagina was discussed, a participant noted that this could be done by both women and men, and was referred to as rape. Two female adolescent participants in one group in Thika, had not heard about lesbianism.

Analysis of interviews and group discussions provided no additional patterns of consensus on understandings of definitions and contexts in which varied forms of sexual violence such as penile-anal penetration of women are referred to.

5.3 Gender differences in perceptions of what constitutes sexual violence

5.3.1 Sexual violence cannot be said to occur in marital relationships

Rape in marriage was not explicitly raised as a question in this study. It however emerged in all group discussions and elicited diverse opinions.

The general consensus among participants in three groups (two male, one female) in Thika, all groups in Malindi and two male groups in Nairobi was that, rape cannot be said to occur in marriage. This was based on arguments of the implied automatic consent for sex in marriage institutions based on traditional, Islam, and Christian religious beliefs, and in the lack of an explicit legal provision within the laws of Kenya.

Some participants were categorical about the non-existence or rape in marriage,

> *"hiyo kitu hamna" [that thing is non-existent* (adult male, Malindi)].

With regard to social understandings, an adult female participant from Nairobi noted;

> *"kama umemarry unagree na all that comes with marriage na hata kumshugulika bwana wakati wote" [if you marry, you agree with all that comes with marriage including catering for your husband at all times].*

The lack of legitimacy of marital rape was based on religious teachings and inferred from existing practices,

> *"At marriage, women promise to obey ..."* (adult male, Nairobi) - in reference to Christian marriages
>
> *"Biblically, when two people get married, they commit themselves including their bodies to each other. Rape really cannot arise"* (Male, Christian religious leader, Interview)].
>
> *"...I believe there is no rape in marriage (pause)... that is my religion, there is no rape because I am supposed to take care of my wife and she is supposed to sit and wait for me... it is just part of her responsibility that she has to do that..."* (Male, Muslim religious leader, Malindi, Key Informant)

On the legislation of Kenya,

> *"Hata ukiangalia katika zile law zetu, hakuna kitu kama hiyo baina ya watu wameowana" [Even if you look at our laws, there is nothing like that between people who are married* (adult male, Thika).

5.3.2 Sexual violence in marriage is a creation of the feminist discourse

An adult male in Malindi felt that the issue of rape in marriage was a 'problem of Beijing' being in reference to the Beijing platform for Action, and thus an issue of the west, borrowed by women in Kenya. There was general agreement on this point by group participants. This

could be linked to the socio-political resistances to women's movements described in section 3.4.1. It was not probed further by the moderator.

5.3.3 Consensus for sex in marriage and circumstances for sex negotiation

Within all groups there was consensus that both men and women have sex rights within marriage and that consensus should be reached by both parties when having sex. Expressions used to reflect this need included

'come to agreement' (adult male, Nairobi)

'mambo ni maelewano' [things are about understanding each other] (adult female, Malindi)

'mutual understanding' (Male, Muslim religious leader, Malindi, in-depth interview).

The circumstances of consensus building and negotiation of sex rights, such as who initiates sex, how much power each partner wields, the processes used in bargaining were not explored extensively. It was however clear from the data that men command considerably more power. There were divergent views on the ways in which these sex rights are expressed. Adult male participants from groups in Thika and Malindi noted that wives were able to express their sexual desire directly through asking or through certain expressions such as the kind of clothing they chose to wear to bed (box 5.1) or their sleeping styles. One adult female group in Nairobi felt that women were often unable to express their desire for fear of the perceptions of their partners. Commercial sex workers felt that men were the initiators of sex, and therefore were largely in control of sexual activity between partners.

5.3.4 Consent, coercion and force in marital sexual relationships

What is considered consensus and, the extent of sex rights for both men and women could not be determined from the data. The findings suggest inter-linkages between these two concepts. Findings also suggest fuzzy boundaries between what is understood as consensus, coercion and force. Coercion appears to be perceived as a way of acquiring consent to have sex. The quotes below attempt to capture the problematic nature of consensual, coerced or forced sex and extent of sex rights in marital relations that emerged in these findings.

An adult male participant from Malindi noted;

"Now to me, it you are married and if I come to you, and you do not want, the idea is to talk to you until you agree. I will persuade you until we get to an agreement... if I do it by force, it is

not rape, it is called, we can call it something else, maybe like an argument, or something, but not rape (adult male, Malindi)

An adult female participant from Thika;

"kama haujiskii na anasema anataka na mnastrugle si hio ni rape" [if you do not fee like it (sex) and he says he wants (in reference to a husband) and then you struggle, is that not rape? (adult female, Thika)].

In the adult male group in Nairobi, one participant was interested in knowing from group participants whether women had similar sexual rights since marriage was supposed to be complementary. In response another participant asked,

"now you, how do you think my wife will make me have sex with her, to say the truth, if that day I am not in the mood, then she is unlucky" (adult male, Nairobi)].

Payment of dowry was associated with unlimited rights to sex, particularly for men in three of the adult female groups (two in Nairobi and one in Thika) and one male adult group (Thika). One adolescents group (female in Nairobi) made links between dowry and sex rights. Participants in this adolescent group agreed that dowry should not be a basis of 'demanding for sex', but that there is need for consensual discussions. Again the nature of consensus building was not clearly defined.

Below is an excerpt of the male adult FGD in Malindi that captures perceptions on the varied issues of women's ability to express sexual desire, the extent of sex rights between women and men, and the blurred boundaries between consensual, coerced and forced sex - issues raised above on sexual violence in marital relations.

Box 5.1 FGD excerpt: divergent views on rape in marriage.

Moderator: *What is the opinion of others in the group?*
P1: *"now, for me with regard to rape, when you go to the Kadhi or Pastor and get married, you agree to everything. For this wife to refuse your terms and conditions that you want, she is not a true wife because she is supposed to agree with you. Possibly if she is on the normal condition (in reference to menarch) then you give her time until she is alright, and if she is fine, I do not see the reason"*

P2: *"but on my side, I will oppose what my friend here says – there are times when your wife, maybe she has been working all day or her body does not feel up to it (in reference to sex), now there is need for discussion and understanding between man and wife so that they come to a consensus…"* (interruption by Kahindi)

P1: *"aaaahhhh you! Sometimes you cannot understand these women. Yes discussions must be there, but there is your responsibility to take charge of things in your house or she will be on menarch every day of the month…"* (laughter in the group)

P3: *"…it's not like that… if we bring experience into this, when my wife is not in the mood for sex, she wears a long piece dress and her pants underneath it. The moment I want her or she wears a leso (1 piece cloth that is wrapped around the body), aaahhh things are fine. If she is not up to it and I am feeling like I want sex, it is up to me to use my skill to bring her over. But this rape business…"*

P4: *"from what this guy has said, there is understanding. Let us say your wife really does not feel like it even with your skill, and as we men know ourselves, we just go ahead anyway and force her, is that not rape?* (2 participants interrupt to talk at the same time)

P3: *"these things are about understanding each other"*

P1: *"this business of rape between a husband and wife- I do not understand…"*

5.3.5 Sexual violence in non-marital relationships

Sexual violence in non-marital intimate relationships was discussed in depth in one adolescent male group in Thika, one adolescent female group in Nairobi, and two adult groups (male) in Malindi and Nairobi. Clear gender divides were present in the findings. Male groups largely did not concur with the existence of sexual violence in non-marital relationships while female groups did. Discussions of the circumstances surrounding such violence were dominant. The term 'the alleged' rape was used three times in two of the male groups.

Participants in one adolescent and one adult male group (in Thika and Malindi) felt that sexual violence cannot be said to exist in non-marital relationships. Engaging in any form of pre-marital relationship was construed to mean 'consenting to the terms of the relationships'. The terms referred to were not explicit. However, the implied 'terms' as emerged from the findings refer to accepting sexual activity as part of pre-marital relationships. For instance, an adult male group in Malindi felt that if girls did not want sex, then they did not need to have relations at all until they were married. It was also unclear who sets the conditions and who is expected to abide by them in the relationship. An adolescent male participant in Thika could not conclusively refer to forced sex as rape, but rather called it "sex by intimidation". The term rape, he felt, did not reflect the complexities of relationships including sexual activity therein. Concerns on accepting rape in non-marital relations raised by adolescent male group in Nairobi, were based on the potential for abuse. It was felt that girls would 'allege' rape even in instances where they had had consensual sex for purposes of revenge, thus rape should not really be recognized in relationships.

Conversely, discussions by female adolescents in Nairobi and Thika reveal a general consensus on the existence of sexual violence in non-marital relationships. In some instances, it is clear that physical force was used and women sometimes were able to actively resist. Means of resistance that emerged could be located in a spectrum from active to passive. They were often linked to some form of negotiation by the women. Negotiation skills and approaches used included pretence to be in menarche, sickness and promises of sex at a future date.

> *"...once I was almost raped but I saved my self by pretending to be sick. I was actually hissing and he thought I was dying...I refused to sit on his bed though he was insisting. The man became violent he told me he was going to sleep with me I either like it or not. The doors were closed. I started acting sick and he left me alone"* (adolescent female, Thika).

5.3.6 Consensual, forced and coerced sex in non-marital relationships

In other instances, the boundaries between force, coercion and consent were not always clear. It was suggested that men are aware of the sense of shame and blame survivors of sexual violence experience. This can be used in a calculated manner as means of coercion for gaining consent. Women felt pressure to consent, particularly if they find themselves in situations

where they may be blamed. Examples of such circumstances offered included sexual violence when visiting a boyfriend in his house. This quote from Thika provides an insight into the issues of coercion, consent, blame and shame associated with sexual violence in non-marital relationships.

> *"Lets say I have a boyfriend and am against the act, but you can be forced. He will come at night when he knows I am there because he want to do ..., and to make me to give him. He knows if he rapes me, I will be disappointed and when others get to know wataniepuka, na wanicheke waseme nilirepiwa [they will reject and laugh at me saying I was raped] - so I will give in"* (adolescent female, Thika)

The complexities of consent and the fuzzy boundaries between forced and consensual sex in non-marital relationships were also presented in data that demonstrates women's (particularly unmarried) perceived inability to assertively say no to sex requests. For example, one adolescent male in Nairobi felt that, *"African girls say no when they mean yes"*, and a female adolescent from Thika explained that some girls do not say 'no' clearly enough,

> *"... if he is used to touching and you tell him no but you mean yes, you know- you are acting shy then you allow him to continue. This could mean you are encouraging him...a no should be a no not a half no, or yes. There is a girl friend of mine who got herself pregnant by saying no. The man removed her blouse as she kept on saying no, then the man pulled her to a chair, later to the bed and had sex, as she said No but did not take action. A no has to be No -make a face that says no"*

Two adolescent male groups (Nairobi and Thika) felt that girls sometimes said no to sex when they wanted sex as it was considered inappropriate for them to express such desire. This sentiment was expressed in both male and female groups across different ages and locations. Thus a 'no' to sex could not be taken literally as such. This apparent lack of clarity in whether or not girls want to have sex was the explanation given by an adolescent male from Nairobi for 'using force sometimes.

5.3.7 Emerging sense of agency regarding sexual relations

Women's limited ability to say no was linked to new social arrangements that do not have a place for imparting sexual knowledge. An adult female participant from Nairobi noted challenges in current modes of sexual socialisation,

> *"...nani anafunza wasichana na vijana maisha siku hizi? Hakuna. Sisi tulifunzwa na akina shangazi ndio tukaweza kujua vile tutaishi na vijana wenzetu..." [...who teaches girls and boys about life issue these days? No one. We were taught by our aunties and that is how we knew how to deal with our fellow boys]* (adult female, Nairobi)

A sense of empowerment around conduct in non-marital relations, including more open communication and an expressed ability to question the nature of existing non-marital relationships emerged among adolescent girls.

> *"if you are in a relationship with a man you should be in a position to talk to him as in you can sit down and believe you are adults and tell him. If you are not ready to do just tell him you are not ready if he does not understand you are with the wrong man"* (adolescent female, Nairobi)

This sense can be complemented by findings in sections above that demonstrate a range of passive and active resistance techniques to sexual violence. These include negotiation skills (5.3.5) such as pretending sickness, menarche and promises of sex in the future. In 5.3.6 an adolescent from Thika asserts that girls do not say 'no' clearly enough. She however clearly demonstrates a sense of agency in how to 'say no'. These data suggest a sense of agency emerging from adolescent female discussions. This sense was not distinct among adult female groups.

5.3.8 Sexual violence against men

From the discussions on local understandings of sexual violence (5.2), the conceptual definitions of sexual violence against men were unclear. Where it was said to happen, it focused on sexual violence of men against men. Sexual violence of women against men was discussed in all adult groups (both male and female). It was dismissed as difficult or impossible in the adult male groups in Malindi and Nairobi, with divergent views from one adult women group in Nairobi. Some group members felt that sexual violence against men was possible and some group members that this was not possible.

"I believe it is about physical strength, so a man who wants to penetrate must fight and it will depend on whether he has more strength. I have not seen a woman stronger than a man or wamekuja wengi wanamshika sasa hapo anshndwa nguvu [or they (women) have come many and held him so that they have defeated his strength] (Malindi, female, adolescent)

Sexual violence against men was described as 'more shameful' and considered a greater crime and violation of the person than that of women by male and female participants. Intolerance at perpetrators of sexual violence, often in relation to young boys was expressed, with three examples of social action such as mob justice and ostracisation of the family against alleged perpetrators. Establishing operational definitions for 'young boys' was difficult from the findings. These feelings of deeper shame regarding sexual violence against men were echoed across all the groups by both female and male participants in the different locations.

"Sodomy is very shameful, even more than rape... you see hii ni kitu ambayo haitakikani kufanyika kwa mwanaume..." [you see, this is something that should not happen to a man (male adolescent Thika].

The notion of male rape was considered an impossibility by some participants, mainly adolescent females, portrayed in reactions such as,

Even a man can be raped. I overheard that - where is a man raped? Actually, I do not know how? (Malindi, female, adolescent)

"na kwani atashikwa wapi ndio afanywe hivyo?" [and where will he be held so that he can be done like that? (adolescent female, Nairobi)

In addition, similar sentiments from male groups were nuanced in the reactions of participants in the findings, rather than verbal. For instance, the excerpt below from the adolescent male group in Nairobi, highlights the initial reactions to the question of adult sexual violence against men.

Box 5.2 FGD excerpt: reactions on the question of sexual violence against adult men

P1: *kwanza hawa wavulana wadogo* [as for these young boys], *they are targets....*
Mod: *How about adult men?*
Pause in the group, one participant coughs
P2: *eehh – yes, it happens....*
(The moderator and note-taker described this pause as an uncomfortable silence)

5.4 Gender differentiated group interactions and language use

Amongst both male and female groups, the explicit use of sex related terms and sexual organs was avoided. These were often referred to by other means from which inferences were made by both female and male group participants across the groups. For instance;

"kufanya hivyo" [to do like that - in reference to sex] (male adult, Malindi),

"kutumia hiyo kitu" [to use that thing - in reference to a penis] (male adolescent, Thika);

"kutumia [to use] the right channel" [in reference to a vagina] (female adult, Thika)

In discussing sexual violence, references used included, *"forcing romance on me"; "forced love"*. The terms romance and love that connote positive feeling were used exclusively when discussing sexual violence within relationships and were used primarily by women.

Discussions of sex and sexual organs were notably less explicit among female participants, with less information expressed with regard to sexual orientations than from male participants across the different ages and locations. In comparing all female groups, adolescents from two groups in Nairobi were more expressive in discussing sexual practices and in discussions on justifications provided for sexual violence in the community. They also expressed more freedom in discussing the varied sexual orientations. The female adolescent group in Thika expressed the most freedom and feelings of safety within the group. They were most open in discussing personal experiences and expressed their feelings around sexual violence more explicitly with arguments on issues where there were divergent views. Female group participants in Malindi were the most challenging in initiating discussions. In the adolescent female group, the first time the term rape was mentioned at the probing of the moderator, there was silence in the group. Participants seemed unwilling to discuss sexual violence. The adult female group discussion in Malindi was described by the moderator and note-taker (both female) as 'difficult' with minimal interaction. The relatively formal nature of focus group discussions may have negatively influenced women's ability to be express themselves freely. It cannot be drawn from these findings whether there is simply a lack of knowledge on sexual practices or the setting was inappropriate for the expression of such knowledge. An analysis of these findings is undertaken in section 5.8.7.

5.5 Causes and justifications for sexual violence

To identify the perceived causes of sexual violence, participants in focus groups were asked, *does rape happen here? Why does it happen?* This section documents and reports the findings thematically as they emerged.

Findings showed gender differences in the causes and justifications given for sexual violence. Participants in male groups seemed to justify and provide reasons for tolerance of sexual violence, though with diverse and strongly expressed opposing feelings therein. Female participants leaned more towards feelings that there was no justification for sexual violence. Findings strongly suggest that women are held responsible for sexual violence that happens to them at social levels and within institutions. I have fit the causes and justifications advanced for sexual violence into three broad themes; perceived transgression of social sanctions, the perceived notions of innate nature of male sexual desire and, external factors such as drug use and the media.

5.5.1 Female forms of 'dress'

Social expectations with regard to dress and discussions on modes of dress and sexual violence were most controversial in all groups. The findings showed that acceptable forms of dress are based on perceptions of 'an African culture' and Christian and Islamic religious perspectives. These were described using terms such as *'respectable', 'decent', 'modest'* and *'non-provocative'* in both male and female groups. There were no clear definitions on what constitutes the dress referred to by these descriptions. However, there were implied descriptions based on forms of dress that were considered unacceptable such as, *'tight', 'non-existent'* and *'transparent'*, clothing. Data showed that participants in all male groups and female groups in Malindi seemingly agreed with these descriptions without unpacking them. Participants in adult and adolescent female groups in Nairobi and Thika had divergent views on the meanings of the terms used to describe dress to different people, and on the understandings of acceptable African dress. For instance, it was argued within the adolescent female group in Thika, that immodesty or a sense of it often depended on one's background. A specific example given was that of differences in perceptions of dress in Kenya, where people from the rural area may find women dressed in trousers as immodest, but this may be acceptable in the urban areas. With regard to the concept of 'African dress', an adult female

participant in Nairobi questioned what sense of African dress was being referred to in the discussions, since traditionally, most communities did not wear the contemporary clothes found today, if any.

Despite these differences, both male and female participants in all adult groups made associations between the perceived forms of unacceptable dress and sexual violence. It was felt that women wearing such clothing were to blame for sexual violence that may happen to them.

> *"What do you expect men to do when they see you in very tight clothing?"* (adolescent male, Thika);
>
> *"Surely, those tight and transparent things girls want to wear are just asking for it"* (adolescent male, Nairobi);
>
> *"kama msichana amevaa ile immodest dressing, si hiyo kuenda kutafuta wanaume tu?" [if a girl has worn those immodest clothes, isn't that going out of her way to look for men?]* (adult female, Malindi).

Summed up in one participants words,

> *"is it rape if a woman is dressed provocatively and makes your desires go up?"* (male adult, Malindi).

Strong opposition to the associations made between dress and sexual violence was seen in adolescent female groups in Thika and Nairobi. Reference was made to sexual violence against 'decently dressed women' and in particular against Muslim women who wore 'Buibuis' (the plain black garment worn by men as per Islam religious requirements). Sexual violence against children was raised in the context of dress; An adolescent female participant from Nairobi wondered,

> *"na wale watoi wa 1year, 5 ama 12 wanarapiwa, pia wao wamevaa provocative?" (and those children aged 1,5 or 12 years that are raped, are they also dressed provocatively?).*

5.5.2 Women's physical spaces

Women's perceived responsibility to avoid rape was reflected in all female groups and three male groups discussions with regard to time (when) and place (where) that women should or should not go. Women walking at night were an example advanced as to why sexual violence may happen. However, within the same groups with the same participants, it was felt that

women were free to walk at whatever time they so wish, and this was not a justification for sexual violence, while at the same time there were strong feelings that women should not be out late at night. This was however not explicitly identified as a justification, but described as a reason. Suggestions to women's employing self protecting mechanisms included being careful where one walks and at what time, drew consensus amongst participants in all groups. There were no discussions on males avoiding sexual violence, and this was not probed by moderators.

Visiting a man's house was another example given for why sexual violence may happen. There was a clear gender divide in the four groups where this discussion emerged. Male participants felt that women were responsible for sexual violence in a man's house, while female groups felt that the object of women's visit to men's houses was not always sexual. Sentiments expressing this justification included women wanted 'it' (in reference to sex) or were inviting 'it' by putting themselves in situations where it was likely to happen. With specific regard to non-marital relationships, a participant noted;

> *"How can someone talk about date rape, ukienda kwa huyo mwanaume si unajua ni nini unaenda uko kufanya" [when you go to the man's house, you know what you are going to do there]* (adolescent male, Thika)].
>
> *"... girls put themselves in this situation and should not be blaming men"* (male adult, Thika)

5.5.3 The perceived notions of the innate nature and primacy of male sexual desire

There was an implied responsibility on the part of women to satisfy male desire for sex, which if not satisfied could lead to sexual violence, from both male and female groups.

The primacy of male sexual satisfaction emerged in male groups (both adolescent and adult), and it was also here that opposing views were strongest. The need for men to have sex, regardless of the circumstances was also accepted within female groups (both adolescent and adult). Male sexual 'desire' and 'urge' were described as 'natural' and as 'biological'. Sexual violence was justified by some participants on this basis. Women's sexual needs were perceived as more responsive to male needs, primarily within adolescent male groups. The following excerpts of two group focus group discussions highlight these findings.

Box 5.3 FGD excerpt: perceptions of male sexual desire as justification for rape by the adolescent male group discussion in Nairobi.

P1: *"If a man has approached a girl for long and she has refused to have sex, then he may rape her"* (male adolescent, Nairobi)
Moderator to P1: What do you feel about that situation?
P1: shrugs
P2: *"hauwezi kuenda around ukirape everyone who refuses kukupatia. Ni kama kusema manzi anikatae alafu??* [you cannot go around raping everyone who refuses to give you (in reference to having sex with you). Its like saying a girl refuses me and then what)

Box 5.4 FGD excerpt: perceptions of male sexual desire as justification for rape by the adolescent female group discussion in Thika

P1: *"...a man and he is married and is with the house girl there and maybe the wife doesn't care about the husband (in reference to not providing sex), what is he supposed to do? He can rape the girl"*
P2:*"so are you saying it is fine for the husband to rape the house girl?*
P1: *"no, but somehow you have to see the other side of things"*
P2: *"what side of things?* (raising her voice) *You know what, there is no excuse for rape*
Moderator: *what do the others think?*

There were divided feelings from the group where some felt there was no justification and other felt that it might be justified.

In the two male groups (Nairobi adolescent, Malindi adult) where male sexual desire was seen as primary, distinctions between forced and consensual sex were most blurred. In addition, the findings suggest perceptions that men who perpetrate sexual violence cannot help themselves, and that this is their nature.

Counter debates on the expressed sexual need for men, focused attention on the implied lack of self control by men. This question was raised in the context of discussions on: dress where it was implied that men would engage in sexual violence, primarily on the dressing mode of a woman, women visiting men's houses, male sexual desire. It was noted that while there are increasing reports on sexual violence, there were few men who were perpetrators. Some

participants expressed strong sentiments around the complete lack of justification for sexual violence. With regard to concerns and perceptions on self control, an adult male participant from Thika questioned;

> *"what do you people mean? Surely surely, we are not animals, we can control ourselves"* (male adult, Thika)].

5.5.4 Drug use and the media are factors that influence sexual violence

Three key external factors were identified. They were agreed on by the group participants where they were identified and did not raise much debate.

Drug use and abuse: Rape was also seen to be caused by drunkenness, either from alcohol or drugs and this was reflected in the different groups.

The media: 2 adolescent groups in Nairobi and 1 in Thika felt that the media was partly to blame. The media were seen as encouraging sexual desire that could lead to rape.

"All there is on TV is just sex, sex and more sex" (adolescent male, Thika, FGD), which was seen to encourage sexual desire that could lead to rape.

HIV/AIDS related myths: Myths that suggest that an HIV positive person will be healed through sex with a virgin were seen to contribute to rape especially of young children.

5.6 Awareness of support and care services for survivors by communities

- What are the community/survivor perceived priorities for a good service?

In understanding community/survivor perceived priorities for a service, I first sought to understand how situations of sexual violence are resolved and asked the questions; *how are these cases/situations resolved? What support services are available in the community?* The effects of sexual violence were discussed in the context of the services required for care and support. Probing was on what happens/should happen in situations of sexual violence, participants' understanding of existing mechanisms for sexual violence care, procedures for seeking police, health and legal aid and perceptions towards services delivered by public institutions in this context. Participants were also asked; *in your opinion, what should be provided for survivors? What should be done to minimize the constraints for access to services? And who should be involved and how?*

5.6.1 Negative effects of sexual violence

Both female and male groups saw immediate emotional stresses and reactions as the effects and outcomes of sexual violence. These included long lasting phobias, that were seen to affect relationships with the opposite sex thereafter and resulted in mistrust and withdrawal. One woman explained the long lasting fearful effects of an 'almost raped' experience:

> *"Once I was almost raped...from that time I could not sit on a man's bed and I could not be left with a man in a house. I lived with that fear for 7 years then I was able to deal with it. I could not have a boyfriend because of the fear"* (adolescent female, Thika)

The effects of rape by partners (boyfriends and husbands) and by family members or close family friends was discussed more in female groups (5.2.1) and was seen to have most negative effects emerging from helplessness felt in these situations. Resultant behavioural problems such as alcoholism and drugs and broken relationships were noted. These were seen to include divorce at times. Physical problems associated with sexual violence included bleeding, shock, vaginal wounds. A few participants, predominantly female (both adult and adolescent), highlighted the possibilities of infection with Sexually Transmitted Infections (STIs), including HIV, and pregnancy was the most likely outcome mentioned. While participants noted that HIV is transmitted primarily through sex, there seemed to be no explicit connection between rape and HIV transmission.

5.6.2 Awareness of services and existing mechanisms for uptake of services

Awareness of what to do if sexually violated was diverse within all groups. Some participants felt that the police station should be a first stop, others the hospital, others the chief's office for reporting. The role of the police was seen to include, recording statements, apprehending the perpetrators and providing evidence in court. There was consensus in all groups on the need to go to the hospital. However, it was felt that services at the hospital were often lacking. In two male and one female adolescent groups, there was reference to a process of 'cleaning' done at hospitals. This was vague and seemed to describe some unknown process undertaken in the hospital to clean the vagina and was discussed with health providers (section 7.2). There was no knowledge among the group participants on what could be done to prevent infection of STIs including HIV and pregnancy in the event of rape to avoid infection. Two adolescent groups noted that pregnancy prevention medication (emergency contraception) was available and should be provided. Management of disease

was seen to be possible after the establishment of infection when the survivor began to experience symptoms of any outcomes. A participant (adolescent male, Malindi) suggested blood transfusion to change the HIV status of someone who finds that they have HIV after rape, but noted that it was a costly and hi-technology process that had to be done out of the country.

5.6.3 Awareness of links between sexual violence and HIV

HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) cannot be de-linked from sexual violence. The risk of HIV transmissions increases in sexual violence (2.5.1-3). It was therefore important to understand participants' knowledge of HIV and its links with sexual violence. All participants in all groups had heard about HIV/AIDS. Most information on HIV infection, transmission and progression to AIDS was correct. There were few participants who had incorrect information on HIV such as, HIV is transmitted through sharing towels or cutlery with infected persons (adolescent female, Thika) and Anti-retrovirals if taken for 10 years can cure HIV (adult male, Malindi)

There was no knowledge and/or awareness of the existence and use of post-exposure prophylaxis in particular. In Thika, a participant from a male adolescent group had heard about PEP and that it was available at the Nairobi Hospital (an exclusive private hospital), and would function within 24 hours of exposure, and was not aware of the mechanisms of action. There were questions to the group moderators on PEP and its functioning from all groups. These were deferred to the end of the discussions when they were answered.

Box 5.5 Questions frequently asked by group participants with regard to PEP after FGD sessions

Questions most frequently asked by participants revolved primarily around PEP therapy:

- How PEP works,
- How sure the moderators were that it works
- How much the moderators know on the safety of PEP
- What advice the moderator would give about where people should report first- the hospital or the police station

The moderators answered these questions with facts on PEP and suggestions for referrals. On where people should report first, moderators provided information on the necessity for taking PEP at the earliest possible moment after rape.

The police and health care facilities were identified as the key service delivery points with regard to sexual violence. Religious institutions (particularly, churches) were identified as key support services in the community by all (female and male) groups in Thika and all female adult groups in Nairobi.

5.7 Perceptions of constraints and challenges faced by survivors in accessing services

Participants were asked; *what constraints are faced by those who have been raped and their families? What can be done to minimise these constraints?*

Fear of stigma and shame of sexual violence was the most commonly referred reason for lack of reporting sexual violence to family, health facility and police in all group discussions and by all key informants. The group participants' understandings of stigma were not explored in any of the focus group discussions. Implied understandings can be drawn from findings that associated stigma with feelings of shame by the survivor and by their family or friends, guilt and embarrassment. Stigma, shame and blame were often used interchangeably in the group discussions and in the interviews. The rationale advanced for stigma and shame experienced was that survivors felt that they were to blame for both the violence and for transgressing social sanctions against extra and pre-marital sexual activity. These sanctions were implied in references to 'African culture'. For instance an adult male participant from Nairobi noted that,

"for Africans, sex before marriage is a shame" when discussing sexual violence.

In two adolescent (Nairobi and Malindi) and one male adult group discussion (Nairobi) and one adolescent female (Thika) discussion, the increased possibilities of female survivors being rejected by men (either as current or future husbands) were noted by participants. Thus, women will rather not report sexual violence;

> *"...fear of losing market with men" [meaning that they will not be able to get men to marry them]* (adolescent male, Nairobi)

or as expressed in Thika, *"no one will want them"* (adolescent female, Thika).

Intimidation was reported as a mechanism to keep survivors quiet, especially in circumstances where the assailant is known to the survivor, the assailant is in a power position relative to the raped person as in the cases of incest, marital sexual violence or violence by employers, doctors or the police.

With specific regard to marital sexual violence, two adult female groups (Nairobi and Malindi) noted the possibilities of physical violence if one resisted sex in a marital situation or the use of force to obtain sex. One adult female participant in Nairobi expressed concern over the repetitive nature of violence in familial relationships, often being discovered after it had been on-going even for many years.

> *"kama imefanyika [if it has happened] once, it will happen again and again"* (female adult, Nairobi)

Fear of stigma and blame by service providers in the health and justice sectors was noted in all groups as negatively influencing uptake of services. It was felt that women are blamed for sexual violence and within these institutions, the blame is openly expressed in questions asked and the nature of treatment given. In all groups, participants felt that police attitude towards and handling of sexual violence did not encourage reporting. Questions asked by the police are often humiliating were seen to increase the 'suffering' of the survivor (female adult, Nairobi). They may even accuse you of just trying to get an innocent man arrested.

> *"si alikuwa rafiki yako?...na mbona unataka kumsingizia? ....si nyinyi mnajuana tu?" [Was he not your boyfriend? Why do you want to plant crime on him?... you people know each other* (adolescent female, Nairobi)].

However, in two female group discussions in Nairobi, some participants felt that the police were improving and doing 'a good job'. It was noted that it often depended on the particular police person whom the survivor found at the station as some were very helpful and supported the survivor.

Health facility services were provided insensitively with health provider language and attitude being cited as most discouraging in all groups. One adolescent male participant noted that it was the women health providers who were most insensitive when most survivors were women. In addition, services at health facilities were seen to be poor in all

groups. These were limited personnel in hospitals, services were expensive for those who could not afford to pay cost-sharing fees and there were no counselling services available at the hospitals.

Services that should be available for post-rape care identified included counselling, physical examination and filling in the P3 forms (forms provided in police stations that are filled by doctors on examination of any assault cases).

5.7.1 Service provider perceptions and their influence on service delivery

In describing service key informant priorities for post rape care services, I first sought to understand their perceptions towards sexual violence; *what is rape/sodomy?* Thirty four key informants were interviewed (table 4.4). This was premised on the understanding that delivery of services in influenced by perceptions of which they are part of the community (1.2; 2.3.2). They were asked about the challenges and constraints that, a) survivors face in taking up services and, b) influence their own delivery of services. For instance, the police were asked; *what constraints/challenges do survivors face from your perspective? What constraints/challenges do the police face in delivering services to survivors?* The themes emerging from analysis were stigma, blame and service provider attitudes as key influences for delivery of services for survivors.

Two of the police officers, two legal officers, one medical officer and the forensic expert were aware of a recent inclusion of sodomy as a punishable offence in the law. Two police officers and 6 key informants referred to sodomy as 'an unnatural offence' in accordance to the laws of Kenya (3.7) with no distinction. All key informants referred to rape as forced penile vaginal penetration and made a distinction between rape and defilement, noting the latter to refer to children. However, only five police, two legal officers and a forensic expert were clear on the exact details additional legal caveats such as age distinction, aspects of force or intimidation and consent.

The police noted that working with survivors was difficult. The police understand their role as to cross-examine the survivor as a person reporting a crime just like they cross-examine other people. Survivors of sexual violence were said to be challenging to the police for two

reasons. *First,* they required accompaniment to the hospital in a context of limited human resources and, *secondly,* they were often not responsive to police questions. Two police informants noted that the age of the survivor sometimes made the exercise of questioning even more difficult. A police officer in Malindi noted;

> *"Questions seem to be intimidative to them... you can't ask some things like from the old woman... many are just quiet"*

Service providers raised concerns on how survivors are provided services by other groups of providers. For instance, health providers felt that police were inconsiderate of survivors and 'made fun of them'. A medical officer and one laboratory technician and one nursing officer felt that health care services were not friendly to survivors.

> *"...you see they come to the facility and nobody is sure where they should go. Also, if they are in casualty it is hard to know what they are presenting... mainly it is just examination for the P3 form and nowadays HIV testing. Sometimes even the Doctors are not comforting with them"* (male, laboratory technician, Thika)

All VCT counsellors felt inadequate in providing counselling services to survivors, with one noting that they were *'uncomfortable'* (Female, Malindi). Two counsellors felt that other health providers were *'judgemental'* to survivors, and that many times *'curiosity questions'* were asked by clinicians. In qualifying the term judgemental, one counsellor (female, Nairobi) gave an example if a girl presented in *'tight clothing'* or was *'in a disco'* when rape happened, noting questions such as;

> *"...and you were dressed like this? Or what were you doing there?"*

One key informant summed up the concerns raised within the focus group discussions and by service providers;

> *"It is clearly amazing how violated women are suddenly blamed for having put themselves in their situations, for having asked for it... everywhere they go, the hospitals, the police, the churches.... it is no wonder that women just don't report"* (female, NGO manager, Nairobi, in-depth interview).

5.8 Discussions: implications for health sector delivery and survivor uptake of post rape care services

5.8.1 Understandings of sexual violence are constructed along gendered identities

The varied perceptions of sexual violence were constructed along gendered lines. Women acknowledged the existence of sexual violence by persons close to them including intimate partners. Men and boys generally viewed sexual violence in the context of unknown perpetrators and did not perceive coercion and even force as a form of sexual violence. This may resonate with Seymours[9] views that sexualisation nutures male children towards being sexually aggressive (2.4). Expectations were that when women engage in relationships with men, then there was implied automatic consent for sex, seen in discussions on non-marital relations (5.3.5) and the perceived social norms (5.5.2). This was extended to marital relations where it was clear that women have no space for making sexual decisions and this is structurally supported by legal and social frameworks, including religion (5.3.1). These expectations are in line with constructions of masculinity and gender power relations as community factors that influence sexual violence cited in literature and in the Kenyan context (2.6; 3.5).

In acknowledging universal sex rights of individuals, participants in group discussions pointed to the need for 'consensus' when 'deciding to have sex' in marital relations (5.3.3). While the circumstances of consensus building or negotiations such as who initiates sex, how much power each partner wields in the bargain were not explored extensively, it is clear from data that men command considerably more power. The traditional requirements for dowry[260] (3.5) and the lack of legal and religious sanctions against marital rape can be associated with male ownership of women and perceived unlimited sex rights (3.5; 5.5.3). These may be argued as contributing towards the implicit sanctioning of sexual violence within marital relations. The absence of explicit recognition of marital sexual violence in Kenyan law thus points to a legal subscription to unlimited rights to sex within the institution of marriage regardless of consent of either woman or man. Given the high proportion of sexual violence against women, this absence of legal protection is inimical to women.

Women had sex when coerced to avoid the consequences of being labelled as 'raped' (5.3.6). The fear of stigma and 'labelling' and consent given to avoid this fear on the part of women creates an additional complexity in attempting to define rape and/or coercion. In this context, to what extent would 'giving in' be perceived as consent and to what extent would it be force, particularly in the context of varied definitions and understandings of sexual violence? (2.4.2). This was made more problematic by the use of language that insinuates positive feelings in the context of sexual violence by intimate partners, for instance, 'forced love' or 'forced romance' (5.4). While I acknowledged that the use of these terms may be associated with, a) language barriers in the use of English and Kiswahili, and, b) the lack of explicit use of sexual terms among women (discussed further in 5.8.7), it drew attention to the perceptions of women regarding sexual violence perpetrated by men in the context of relationships (marital or non-marital). Drawing on literature (2.4.2), these justifications may be framed in the context of women's sexual socialising and to the unquestioning acceptance of family and patriarchy (2.4) that appear to have been reinforced by the African women's movement in their critique of the priorities of Western located feminism (2.4.1). I would suggest therefore that the understandings of sexual violence by women and men though appeared to be at opposing ends, are in convergence so that sexual coercion is sanctioned by women.

Regarding service delivery, the different perceptions of what constitutes varied forms of sexual violence showed that there are key differences between local understanding and interpretations and the Kenyan law. These differences can have important implications for both health and legal practice. For instance, a clinician may examine a survivor who has experienced forced anal penetration and document 'rape' as their key finding without specifying the actual penetration type. Since this is not the legal definition of rape it presents a legal loophole through which justice could be denied. Since this does not tally with the legal definition of rape in Kenya, such a case may be thrown out of court.

5.8.2 Implicit sanctioning of sexual violence

The lack of clear boundaries between coerced, forced and consensual sex in Kenya has been described (3.3). From this data, I suggest two main associations between the gendered constructions of sexual violence and the fuzzy boundaries emerging in the findings.

First, gendered expectations of sexual practice in Kenya are contradictory. Men are expected to have various sexual partners, while there are significant social sanctions against women's involvement in pre/non-marital sexual relationships. Questions regarding where men should source their female sexual partners remain silent within these social constructions. This creates a paradoxical situation, and could be argued to contribute towards implicit sanctioning of sexual violence (men can/should have sex at will and women should not), thus blurring boundaries between consent and force and coercion.

Secondly, there is the tension between traditional and modern conceptualisations of sexual activity. An example is the frequently-raised issue of women engaging in 'sex' before marriage. One adult male from Nairobi noted in a discussion on reasons survivors face shame following sexual violence that, *"for Africans, sex before marriage is a shame"* (5.7.1). This comment implies no distinction between forced and consensual sex. This may be linked to self-blame experienced by survivors as they are blamed for 'engaging in pre-marital sex'. It also draws attention to the highly problematic nature of the notion of 'African culture/traditions' (explored further in 5.8.5) and that were regularly referred to in discussions with regard to gendered expectations of pre-, marital and extra-marital sexual practices and norms. These findings underpin the extent to which emerging ideologies dictated by religion (sexual suppression through constructing sex as shameful), and new gendered constructions of sex (2.4.2) have permeated local understandings of sexuality and sexual practice.

I also draw links between these two associations and the absence of a legal framework for marital rape. I suggest that this legislative shortcoming reflects and reinforces the perceived notions of the primacy of male sexual satisfaction that emerged in the group discussions (5.5.3) as justification for sexual violence. Perceptions of women's responsibility to satisfy the innate nature of male sexual desire can be linked to this absence of a legal framework and suggested unlimited male sexual rights, since the progression to marriage is an expected part of the social fabric for women and men.

5.8.3 Temporal changes and de-construction of sexual violence

A sense of women's empowerment around relationships and expressions of women's agency around sexual violence is seen in adolescent girls' (5.3.7). This sense does not emerge distinctly among the women's groups. The emerging sense of emancipation may arguably be seen to challenge women's vulnerability and contribute towards resilience to sexual violence and reduced vulnerability to HIV infection. This may be a reflection of temporal changes that may be related to dynamic experiences of gendered identities among adolescents vis-a-vis those of older women in diverse Kenyan contexts. It could also reflect heterogeneity of experiences of femininity and socialization (2.4). However, these changes were not seen across the different regions but analysis suggest that they are concentrated in the cosmopolitan region of Nairobi - Kenya's capital, as seen in the two female adolescent group discussions. So, while this sense of empowerment challenges dominant ideologies of women's subservient role in relationships, it draws attention to the difficulties of generalization embedded in its localized nature. Arising questions may revolve around whether women/ girls in other settings really have no agency and are completely powerless?

The question that emerged for taking this study forward was how best this emerging sense of emancipation and threads of resilience presented could be built into the service delivery programmes following presentation. For the long-term, I noted the need to build these considerations into community education and awareness building programmes discussed in chapter 9.5.

5.8.4 Stigma attributed to sexual violence against men

The boundaries between sexual violence against men and consensual sex between men were unclear from the findings. There were diverse and often conflicting understandings of the terms associated with male sexual activity (whether forced or consensual) (5.2).

Gendered constructions of masculinity assume male resilience to sexual violence. For some participants, notions of consensual male sex were challenging thus it could only be forced (5.2.3). In group discussions, male rape was described as 'more shameful' than female rape (5.3.8), a feeling that was common among both male and female group participants in all

areas. Statements such as 'it should not happen to a man' (5.3.8) may imply the perception that it is acceptable for 'it' to happen to a woman. These social perceptions are extended into the legal framework where the Kenyan definition of rape (penetration of the vagina by the penis) was limited in that it excluded all forms of sexual violence towards males, with the exception of males of below 14 years of age, where sodomy was a criminal offence (3.7.1). This legal status reflects perceptions and assumptions of the impossibility of sexual violence towards males. However, from the findings (5.3.8) male sex is known to happen. I hypothesize that because sexual violence takes away perceived individual control and results in feelings of powerlessness and shame by the survivor (2.6), it challenges the gendered identities on which masculinity is based, rendering it highly stigmatised.

5.8.5 The concept of an 'African culture'

Much of the discussions on causes and justifications for sexual violence (5.5) was framed within the concept of an 'African culture' and 'African traditions' that were regularly referred to in discussions. The whole notion of an 'African culture' is highly problematic (hence the term is in quotations). Based on an assumption of social-spatial homogeneity across Africa, it ignores hundreds of different ethnicities, cultural orientations and practises (2.4.1). For instance, discussions on 'pre-marital sex' as 'non-African' ignore African communities in which women are expected to be sexually experienced before marriage (such as the Akamba in Kenya) and the conceptualisations of sexual activity (2.4.2) described in the literature. Reference to 'African culture' could signify a shift from community specific norms and values towards more national identities and values. However, it could equally be argued that the term indicates a social vacuum where people are not sure of the norms to which they should subscribe.

5.8.6 Perceived transgression of social norms and delivery and uptake of services

Perceptions of acceptable behaviour for males and females are constructed along social norms. Where these 'rules' are transgressed, there are consequences. Dress was raised in every group discussion and by all key informants (5.5.1; 5.7.2). Dressing 'provocatively', 'in tight clothes', or having 'non-existent' or 'transparent' clothes were often described by both women and men as 'not African', and used as a justification for sexual violence. Descriptions of what is acceptable dress appeared to be based on inaccurate descriptions of traditional clothing

(traditionally most Kenyan communities did not wear much clothing, if any). Again, this speaks to the potential lack of norms and values considered 'African'. These justifications ignored the many rapes that happen to young children and Muslim women wearing 'Buibuis'[9]. Regarding service providers, their perceptions of dress do not differ much from the broader community (5.7.3). I therefore suggest that provider practices are shaped by their own values that are based on those of the broader society. This impacts on service delivery. Tensions arising over women's dress may also be associated with part resistance to perceived increase in self-expression by women that challenges masculinity. Thus, discussions on dress could be viewed as an extension of the socio-political resistances that are part of the Kenyan trajectory of sexual violence activism (3.4.1).

5.8.7 Discursive practices on sexual activity

The gender differences in group discussions experienced in this study may be attributed to the social constructions of information use and access by men and women. Gupta & Weiss (1993)[314] offer some explanation of these trends in their suggestion that many cultures dictate that 'good women' be ignorant of sex and passive in sexual relations and that overt seeking of knowledge may be construed as promiscuity. Therefore, women's ignorance in sexual matters is an expectation of many cultures. However, this assumption is made problematic by literature (2.4.2) that describes African traditional frames that were characterised by various forms of sexual activity and information exchange. I draw on the tensions between the traditional and modern conceptualisations of sexual practice that I identified (2.4.3). I suggest that this tension is extended for communication of sexual information. Section 5.3.2 highlighted this with a participant who wondered about the current place of education on sexual communication, noting its presence in the traditional setting. In this study, we were unable to tease out whether knowledge was lacking, or is simply not expressed in the setting of the study.

There were age differences in discussions that may be attributed to varied exposure between adults and adolescents. For instance, in group discussions adolescents often referred to the role of the media in the promotion of sex and by extension sexual violence (5.5.4). This is a

[9] Buibui's are plain black garments worn by women as per Islam religious requirements that cover the whole body.

reference not seen in adult groups. Differences in information access and use by age highlighted the question of 'whether the openness in discussing sex and sexuality by adolescents is an attribute of temporal changes' Further enquiry could be made into the possible ways to influence the role, responsibility and interest of the media in changing attitudes that promote and perpetuate violence.

Chapter 6 Priorities for post rape care services in Kenya

6.1 Introduction

Findings in this chapter refer to objective 1 of the study and focus on health provider and policy maker priorities for establishing post rape care services. Data were obtained from methodology described in section 4.3. Section 6.1 documents findings of health sector response to the physical (biological) and psychological consequences of sexual violence. Institutional responses and support systems are described in section 6.2. In section 6.3, I draw on the findings from chapter 5 and 6 to identify a minimum standard of care, and support systems required to deliver this minimum standard. Finally, I reflect on my interpretation of the findings (6.4).

6.2 Post rape care services as delivered

- *What are the priorities for post rape care services?*
- *What is the minimum standard of care for post rape services?*

Key informants provided information on issues, gaps and challenges for implementing post rape care services in health facilities Kenya. Study findings in this section appeared to reinforce information provided during informal interviews (3.98.2) undertaken at the beginning of the study.

Table 6.1 Services for post rape care as delivered in the three health facilities

Service	Thika	Malindi	Rachuonyo	Comments
Responding to the physical health consequences of sexual violence				
Treatment of physical trauma	√	√	√	
Prevention of STIs	√*	√*	√*	*STI drugs provided for syndromic management
Prevention of HIV	√*	-	-	*used for occupational exposure
Prevention of pregnancy	-	-	-	
HVS for STIs screening	√	√	√	
Intravenous blood drawing for syphilis testing (VDRL samples)	-	√	-	
Blood for HIV testing	√	√	√	
Responding to the psychological consequences of sexual violence				
Trauma crisis prevention counselling	√*	√**	-	*services offered at DCT by untrained providers **services offered at VCT
HIV pre and post test counselling	√	√	√*	*was provided inconsistently
PEP adherence counselling	-	-	-	
Health sector service delivery support systems (macro level influences)				
Full body examination	-	-	-	Often by nurses and clinical officers
Examination of the perineum only	√	√	√	
HVS done by examining clinician	-	-	√	
HVS done at laboratory	√	√	-	
Costs for a card, laboratory investigations	√	√	√	
Costs for filling in P3 form at health facility	√*	-	√	*seemed to be dependent on specific health providers
Waiver system-functional to benefit survivors	-	√	-	

Note: Services offered and investigations done were found to be inconsistent for different patients and by the different examiners in each of the health facilities.

6.3 Health sector responses for physical and psychological consequences

6.3.1 STI (excluding HIV) treatment

Drugs for STIs were offered to those survivors whose swabs (vaginal or anal) were diagnosed with pre-existing STIs. Other survivors were asked to present to the health facility after two weeks for screening (including taking another anal swab) after which prescription was done. A syndromic management of STIs approach was taken in these contexts, rationalised through national guidance on STI treatment. Survivors were referred to the STI clinics (table 3.5) in the

health facility to access these services. Screening and STI management were done inconsistently in all health facilities. Treatment and provision of drugs depended on their availability at the district hospital. It was noted by key informants that drugs are often unavailable to be given out and were prescribed for patients and survivors to purchase.

6.3.2 HIV PEP delivery

Drugs for prevention of HIV were not available at any of the health facilities and thus were not provided routinely. HIV PEP is a term that all medical doctors interviewed were familiar with. All medical and clinical officers were aware that a HIV test was necessary in the context of PEP prescription. However, not all were clear about the functioning and mechanisms of ARV action for HIV prevention. For other health providers in both public and private institutions, little was known about PEP - its availability and functioning. The primary rationale was to avoid litigation for any potential sero-conversion. An informant from a private institution, who attended 5 survivors of rape and sodomy (4 female and 1 male) in the year 2002,

> *"we do not offer more than treatment for STIs and sometimes recommend emergency contraception...we really haven't thought about HIV"* (clinical officer, Malindi).

HIV tests requested by the clinical officer were carried out in the laboratory. Dispute was found to exist on the legitimacy of HIV testing done by VCT counsellors who are non-health care service providers. Results from HIV tests with legal implications such as sexual violence were considered valid only when undertaken in a laboratory or by trained laboratory staff. HIV test results were given to a counsellor or other medical worker to allow for post test counselling except in the Rachounyo hospital where this practice was inconsistent. Additional baseline tests (including renal and liver functions tests) associated with PEP, were found to be done by one public service provider before administration of PEP.

The requisite HIV test for PEP administration raised concerns about:

- How informed consent for HIV testing was negotiated/requested at the time of trauma
- The ability of survivors to accommodate information on drugs and all their requirements during this traumatic period (Medico-legal workshop - Kenya/PEP workshop SA).

"how does one deal with HIV at a time when they haven't even began to deal with rape, as a person and from a family point of view?" (participant, NGO representative Nairobi at the Medico-legal workshop).

6.3.3 Prevention of pregnancy

There was limited consideration for the provision of emergency contraception. Routine emergency contraception was provided only at private institutions in Nairobi and 1 public access facility for comprehensive services.

6.3.4 Treatment of physical trauma

In all health facilities, treatment of physical trauma was offered to all survivors who presented. Internal trauma (vaginal or anal) was treated where detected mainly through oral questioning of the survivor. Existing protocols for management of physical trauma were observed. It was noted that examination of children was often not done as clinicians had difficulties undertaking internal genital examinations on children who often suffered high physical trauma.

6.3.5 Trauma counselling

Where a diagnostic counsellor is available in public hospitals, they may provide counselling to the survivor. It was noted by a medical officer in Malindi that survivors of violence were increasingly being referred to VCT counsellors for emotional and psychological support, as these are the only such services available within the district hospital.

Additional challenges for the justice system were noted as the lack of evidence of the long term effects of rape and sexual violence on survivors from the medical background presented in court, as well as in published research as evidence to support what the survivor goes through.

"... the challenge of showing the psychological problems associated with rape when there are no physical injuries is very real. Besides, we really do not have psychological services targeting rape survivors and is probably the reason we have limited evaluation to go by... it's quite tricky to present 'destroyed quality of life and self-worth' to the court" (Lawyer, NGO programme officer, Nairobi)

The litigation process was identified as a key challenge for survivors. Often hearing of court cases is done in public. This means that the survivor will have to recount their experiences and be cross-examined in public. Key informants stressed on the need for closed hearings and psychological and social support for survivors during the litigation process as a key way to begin to get more prosecutions for sexual violence.

> *"...(this) would provide some confidentiality and a sense of privacy to the client. Can you imagine the prospect of recounting in details what may have happened to the public. Where criminal proceedings have gone to court, which is rare, I have seen a client go into depression from that process..."* (NGO programme officer).

6.4 Institutional support systems

6.4.1 Medico-legal linkages

Consensus on a procedure for reporting and presentation of sexual violence could not be drawn amongst the police or health care providers. A clear protocol could not be established either. There was a general consensus that survivors should first report to police then present to health facilities.

The process of examination entailed a physical examination, primarily of the perineum and internal genitalia that was offered inconsistently. One clinician noted that in some instances, the police officer was allowed into the room when the physical examination is being undertaken. Sometimes a speculum examination was done. Speculums, swabs and preservation bags were not available at the designated points of presentation and time was taken as they are collected from the hospital amenity wards or the central sterilising departments after presentation by a survivor. The examiner was often a nurse, clinical officer and rarely a medical officer. For instance, a female clinical officer from Malindi described physical examination as,

> *"A difficult experience...even just talking about it to get the details..."*

The survivor was referred to the laboratory to present samples such as urine or blood for requested tests and to pick up the results. There was limited knowledge on the legal aspects

of sexual violence amongst the medical personnel. Awareness on the primacy of medical investigations to the justice process was not expressed in the findings from interviews with health care providers.

A high vaginal swab was taken and laboratory investigations focused on testing for spermatozoa. It was reported that where these were negative, survivors found it difficult to prove sexual violence, although rape in Kenya is legally occasioned by penetration. Principal to the reliance on high vaginal swab was the assumption that spermatozoa, rather than penetration, are a definite indicator of rape. Challenges posed by this assumption occur where objects other than the penis were used, condoms are used, there is no ejaculation or penile withdrawal was done. It was noted that the presence (or absence) of spermatozoa, and/or vaginal trauma was often used *"as a yardstick"* for evidence of sexual violence. This was seen as incomplete and a key informant noted some of the key shortcomings with these assumptions:

> *"supposing the raped person is married and had sex with their husband a day, 2 or 3 before the rape? Unless you then have a DNA test to show whose sperms those present in the wet prep are, you cannot use that as evidence, any lawyer will trash it"*

and with regard to injuries,

> *"there may be no injuries at all. For instance it is highly likely that a para3 (a woman who has had 3 births) will show no signs of injury to the vagina"* (forensic pathologist, Nairobi).

In all the health facilities, clinical officers and nurses were the persons undertaking examination, requesting investigations and initial documentation for legal purposes. There were limited numbers of medical doctors available for duties that are not considered emergencies. These notes on cards were then transferred to the P3 form that was described as *"scanty"* and not very useful for *"proper evidence collection"*. Doctors were also seen to be reluctant to sign up P3 forms since it made them expert witnesses and many were unwilling to go to court. A medical officer felt that they may be unable to adequately provide evidence in court since they did not undertake the examination. In addition court processes were described as *'long, expensive and tedious'*

"there is often such scanty evidence and lawyers know each loophole in the system that often doctors are embarrassed in court and they have become increasingly unwilling to sign P3 forms.... In any case, this should be work of the police surgeon" (Clinical officer, Nairobi)

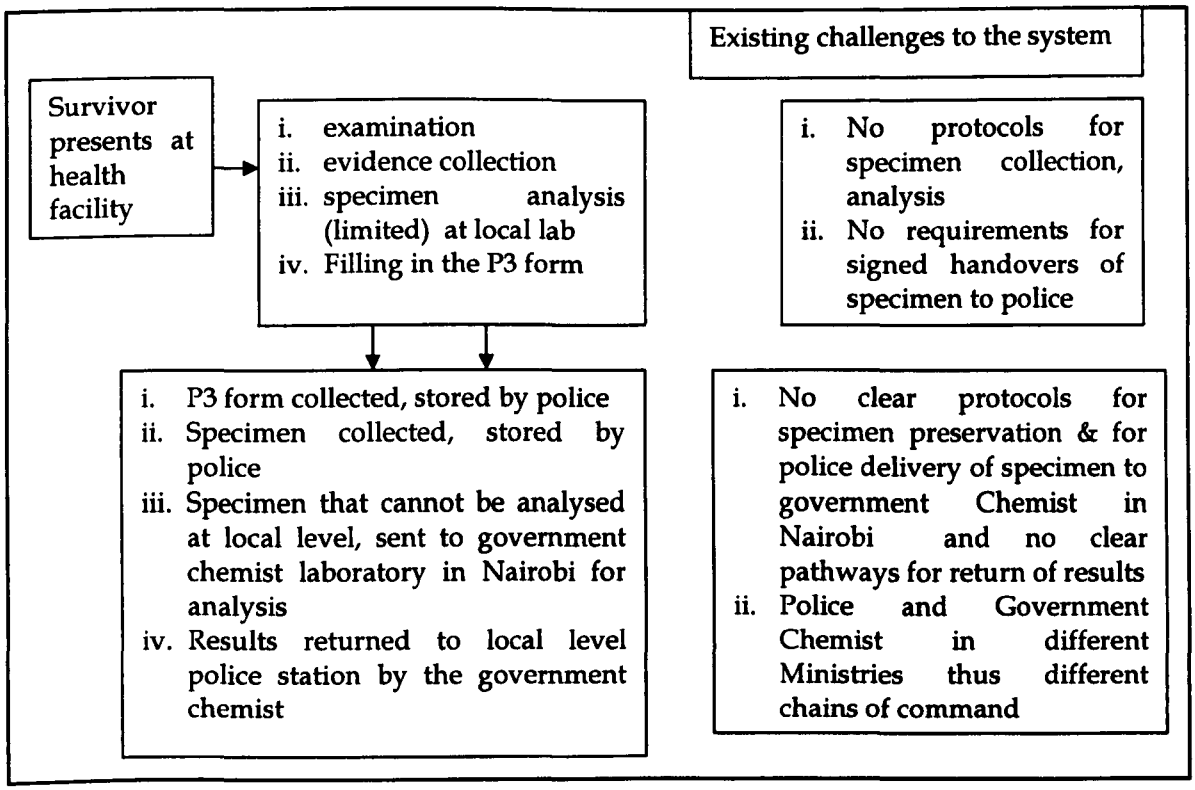
In addition, information taken was often based on the injuries around the perineum with limited information on the history of the survivor, the history of the occurrence according to the client, the medical history that may have implications such as obstetrics and gynaecological history that may provide corroborating information. Additional information on injuries in other parts of the body was not recorded thus loosing vital evidence that could potentially be supportive of the survivor's history of the occurrence. Other information noted lacking from the P3 form and notes normally taken by examining physicians included that of laboratory requests and tests and where these were provided, they were ad hoc with no defined standard.

In all three health facilities, there was no existing chain of custody of evidence. Police picked up P3 forms and any evidence from the health facilities without signing for these. Understanding of preservation of evidence was lacking with no protocols or guidelines hence this was inconsistent and almost never done at all. 'Losses' of evidence were described by health workers as there were no accountability mechanisms.

Systems for linking medical evidence collected and documented to the criminal justice system were linked to two key challenges. *First,* was the lack of evidence by police to support medical evidence availed in court. Investigations were seen to be poorly carried out and the police rarely followed up on rape cases. Where this was done, findings suggest police incompetence to act as prosecutors since they did not have legal training. *Secondly,* where evidence was available from the scene or the survivor, there was no system to ensure safety, access to the government chemist for analysis and utilisation of these results. This was associated with the presence of one government chemist located in Nairobi, where samples were expected to be brought to and the challenges of disparate facilities at the health centre level (3.9.2). The lack of a harmonised system for preservation and evidence handover was noted. It was acknowledged by a key informant with the government chemist that in Nairobi, there are many more samples and evidence that end up at the government chemist than from

other districts. Information for the public on what to do to preserve evidence was lacking. Figure 6.1 contains a flow chart which depicts the chain-of-custody of evidence

Figure 6.1 Flow chart of the chain-of-custody of evidence



6.4.2 Patient records and client flow mechanisms

Long queues in the service delivery points and repetition of survivor experiences to different health providers were reported to be humiliating. It also contravened confidentiality requirements, a right for survivors. A survivor has at the time experienced the most traumatic event that left them feeling violated, ashamed and will in the short term experience disorientation, confusion. Waiting in a queue was seen to exacerbate these feelings. In addition, it contributed to the loss of vital evidence that characteristically disappears with time. A working system that allows for services to be provided to the survivor promptly and in confidence was identified as a key constituent of a functional post rape care service.

In one case event described by a key informant,

> *'in 2002, an 18-year-old was raped by her family friend and visited the hospital on the same day but as the queues were too long so she preferred to go back home and return the next day. Unfortunately she was not attended to and finally went to a private hospital after three days. The HVS test was done and no spermatozoa was seen but no grams stain (colouring used in a lab to highlight presence of bacteria and spermatozoa in a specimen) was done'* (Forensic pathologist, Nairobi).

The lack of linkages between the services delivery points was evident from the findings. The services required were offered in largely disparate areas in geographic location at the health facility, in line management (varied departments), and in functioning. These included:

- Casualty and out patient department as points of presentation managed primarily from the health facility
- the laboratory services responsible to the national laboratories
- the counselling services with VCT integrated into health facilities through the national HIV AIDS response and DCT services whose line of accountability was unclear
- family planning services, integrated into health facilities and responsible to the division of reproductive health
- Services for treatment of sexually transmitted responsible to the NASCOP and run semi-vertically
- HIV care services for HIV PEP that are NASCOP vertical programmes

In all health facilities, sexual violence was recorded as 'assault' and not captured in the quarterly returns in the monitoring system. There were no records available on rape for those who presented at the outpatient and without the police. In-patient records required closer examination to understand the nature of ill-health in order to pick out sexual violence as it was not always explicitly stated.

There was no consistency in fees charged at all health facilities. The cost of services was found to be dependent on the institution with no specific government guidelines. Fees common for the 3 hospitals were those of the 'card' (a registration document used for documentation at the health facility). Laboratory charges for the HVS and for STI screening were dependent on each health facility. The waiver systems were not specifically friendly to

survivors of sexual violence. It was reported that survivors sometimes did not access services due to their costs in Thika and Rachuonyo.

The P3 form is a free document provided by the police to assaulted persons. It was however found that police in all 3 stations charge for the costs of the P3 form ranging from Ksh 200 - 500. In addition, health providers in Rachuonyo, and more inconsistently in Thika, were reported to charge survivors for filling of the P3 form (though the cost could not be established). The rationale provided at interviews was that, if this matter was taken to court, it would cost the clinician time and money to be in court and give evidence. It was noted that this was often not refunded by the MoH as was supposed to be the case.

The lack of resources was also experienced at personal levels where it was noted that many rape survivors were unable to access services since they could not afford to pay the required fees. This echoed the perceptions of participants during group discussions who felt that services within hospitals were expensive for people who could not afford even a decent meal. It was also noted that rape was often unexpected and did not always occur when a person had money, making it harder for survivors to access post-rape services.

6.4.3 Health provider knowledge and capacities for services delivery

Key informants noted the lack of a policy framework and national guidelines within which to provide services. This resulted in ad hoc services, that are not standardized and

> *"that often depend on the doctor providing them"* (medical doctor, Nairobi).

Reference was made to the need for a regulatory framework although there were no proposed mechanisms for this. Challenges were noted in the capacities of health providers to provide post rape care including clinical evaluation and legal documentation, clinical management with specific regard to PEP. Key informants, both lawyers and doctors noted the need to build the capacity of doctors in collecting evidence from survivors in a way that can be used to build a case in the future. Capacities were critical issues arising from evidence collection at the point of examination.

"Doctors and clinicians need skill and training in proper examination and its importance in rape cases. This will enable them take evidence and preserve it adequately" (medical doctor, Malindi)

Only one medical officer of those interviewed was knowledgeable of PEP administration and management requirements and protocols. HIV was often not considered a priority by service providers, in the study. Counselling skills for crisis prevention in the context of HIV, PEP adherence and preparation of the justice system were lacking. Counselling skills for HIV testing were found primarily within VCT services provision.

With regard to building capacity for service providers, the challenge identified by a key informant was that organisations supporting government capacity building programmes, were targeting the non-frontline service providers within the institutions

"all these NGOs concentrate their training on rank officers, yet the people who actually provide the services and need to be sensitised are the junior officers" (police inspector, Nairobi)

Additional challenges cited by post-rape service providers in health care included the lack of requisite resources to provide the required services with more reference made to the lack of funds to buy drugs, reagents to undertake necessary tests or procure necessary care consumables.

6.5 Priorities for post rape care services in Kenya

The priorities for implementing post rape care services were identified based on the themes emerging from community perceptions of sexual violence and an understanding of the issues, gaps and challenges in health sector service delivery from the findings in this chapter. While many issues reflected the need for targeted community based interventions to deconstruct sexual violence and provide education on impact and the need for reporting and presentation, they fall outside of the focus of this thesis. They were useful in identifying priorities as they provided insights into issues affecting services uptake and delivery, but they were not all addressed explicitly as interventions in the context of this study. They remain areas of further inquiry. The priorities that are relevant for the health sector were captured broadly into 3 key areas that were identified as necessary for implementing post rape care services in Kenya. It is these findings that informed the development of the intervention documented in chapter 7.

There was need to address the meso-level influences on sexual violence. This meant taking into account the community perceptions that influence uptake and delivery of post rape care services. Issues of priority identified included:

- The need for value based health worker training with emphasis on gender, gendered identities, awareness of self values and attitudes and examining their potential impact on services delivery. In addition, health provider sensitivity to different words used to describe sexual violence and their possible meanings, conceptualisations of sexual violence, awareness and understanding of the different local understandings, discursive practices, perceptions of violence in marital, non-marital relationships and of justifications advanced for sexual violence and their implications on services delivery
- The need for health provider awareness of gender diversities and power relations linked to sexual violence and their influences on health services delivery and uptake by their clients
- The need for strategic linkages beyond the health sector in promoting messages around sexual violence services and exploring opportunities for prevention interventions outside of the health sector

A 'standard of care' for post rape services (box 6.1 below), and support mechanism for the delivery of this standard of care were identified.

Box 6.1 Minimum standard of care for post rape services in Kenya

1. **Physical examination, specimen collection, analysis and documentation**
   - Examination and documentation. The examination should cause minimum stress and trauma.
   - Specimen collected packaged, clearly labelled and signed off
2. **Clinical management and preventive therapies**
   - Treatment of physical injuries
   - Post Exposure Prophylaxis
   - Emergency contraception
   - Prevention of sexually transmitted infections (STIs)
3. **Counselling**
   - Crisis and trauma prevention:
   - HIV testing:
   - PEP adherence:
   - Preparing clients for the justice system:
4. **Facilitating referrals for other services such as on-going counselling, legal support and rehabilitation**

Support mechanisms for the delivery of the standard of care identified included:

- Development of standard operating procedures for the delivery of the standard of care including, protocols for examination and legal documentation, clinical management and counselling and data/records keeping.
- Linking systems at the health facility level and internal referrals were required to link the disparate range of services into one package through the development of a client flow pathway.
- At casualty (or the point of presentation): forensic examination, specimen collection and documentation, PEP and EC.
- At the counselling service: trauma counselling, HIV testing, PEP adherence counselling, preparing client for justice system, support of the family

- At the laboratory: Specimen analysis and HIV testing. Specimen collected can be screened for pre-existing STIs where possible. Routine prophylaxis should be offered
- At the clinic where PEP is managed (often the HIV care clinic): on-going PEP management, STI drugs. Follow up sessions should coincide with counselling sessions.
- Referral mechanisms for on-going services

Building the capacity of service providers to deliver this' standard of care' while taking into account the meso-level influences was necessary. Priorities identified for training included the need to:

- Explore health provider perceptions, attitudes and values towards sexual violence and provide training that facilitates reflection of health providers on their values regarding sexual violence and gender with an aim to impact on delivery of services.
- Impart knowledge and skill to targeted health workers on aspects of clinical evaluation, evidence collection, specimen analysis and legal documentation, clinical management and counselling
- Develop the capacities of health facility systems to provide a package of care with the limited resources and variedly availed services
- Enhance the accessibility of requisite drugs, commodities and care consumables

6.6 Reflexivity: my reading of the findings

In reference to findings from chapter 5, I acknowledged that many responses for sexual violence are located outside of the health sector. However, the frame for this thesis and in particular the next chapter emphasize the need for the health sector to take responsibility to meet the health needs of survivors of violence. I also acknowledged that survivor decision and ability to seek health care services and provider delivery of care for survivors following sexual violence were constructed socially and were gendered. These included the range of barriers and positive reinforcements (socio-cultural, institutional and structural, across the micro, meso and macro levels). However, in contrast, service delivery models assume individual ability to present, report and seek support by survivors, with no considerations for the gender dynamics of both service delivery and uptake.

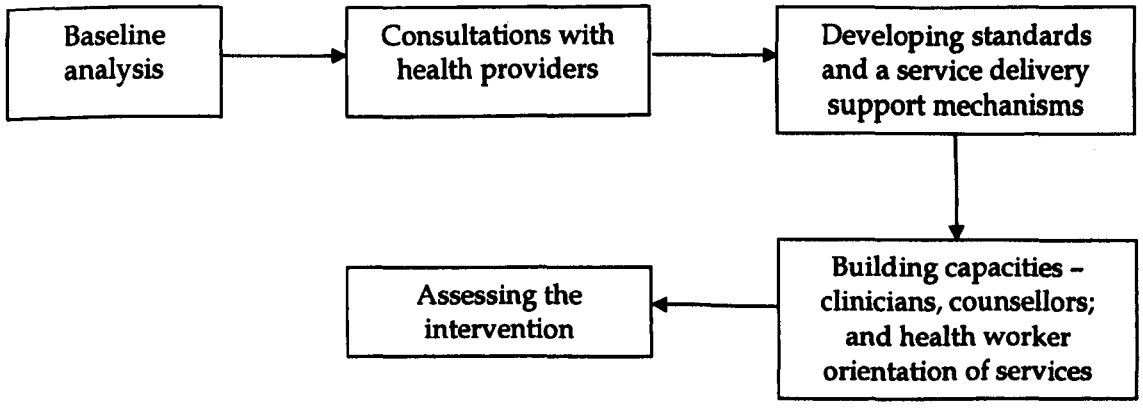
Based on these findings, I was convinced that engendering service delivery required a mind shift in the ways in which medical and public health services were/are provided and that this could be addressed. I felt unable to address the challenges of survivor ability to seek care at community levels because, 1) the objectives of this study meant that intervention was focused on the health sector and, 2) I could not ethically conceive of developing a community and awareness raising intervention without a service to provide the demand for care that such a programme would create. It is with these perspectives that I then developed the intervention documented in the next chapter.

Chapter 7 Documenting the design and development of a strategy for implementing post rape care in 3 district hospitals in Kenya

7.1 Introduction

Findings from this chapter refer to objective 2 of this study, 'to document the development of a strategy for implementing post rape care in 3 district hospitals in Kenya' and were obtained using the methodology described in section 4.4. The priorities for the post rape care services in Kenya identified in section 6.4 formed the basis of developing the set of interventions documented here. Figure 7.1 is a flow diagram of the process of developing post rape care services. This starts with the baseline analysis described in chapters 5 and 6, consultations with DHMTs (7.2), the standard of care (box 7.1), support mechanisms for service delivery of the standard of care (7.5), and health provider capacity building and training curricular (7.3) and ends with an assessment of the intervention. The processes and rationale employed in these interventions are documented. Section 7.4 presents in greater detail the process of implementing these strategies outlining the issues emerging, differences in the district hospitals, challenges and opportunities in this process. I finally reflect on my participation paying particular attention to the gendered influences.

Figure 7.1 The process of developing post rape care services



7.2 Consultations with District Health Management Teams

Consultations were founded on the premise of collaborative co-generation of knowledge (2.9) aimed at attainment of social and institutional changes in the three health facilities. These were first done through a workshop with DHMT members of the three health facilities. Workshop objectives and underlying aims are outlined in section 4.4 of the methodology. DHMTs were selected due to their centrality in health sector delivery in Kenya as the focal points for prioritising and managing health services (3.7.1) at the district. I also wanted to ensure that the post rape care service fell within the interest and priorities of the health facility before developing the programme further (3.7.2).

This workshop drew on pragmatist underpinnings to link the core reflection process of understanding gaps in post rape care services delivery to action outcomes of drawing consensus on possible solutions. The values of health managers were examined, and gendered constructions of sexual violence were explored through exercises borrowed from gender training manuals. During this consultation exercise, we explored the diverse physical and structural (3.7.3) locations of the range of services required for post rape care within the health facility (table 3.3). Discussions on how best to present these services as a package were premised on the appreciation of the health structure in Kenya (3.7.2), the differences between delivery of HIV/AIDS services as vertical programmes and reproductive health services as integrated programmes (2.8.2; 3.8), and the geographically diverse locations for the required services in each health facility (table 3.3). The knowledge and experience of DHMT members as participants were critical to the strategy developed and implementation activities that followed. In the following sub-sections I outline the decisions made (and thereafter implemented) for post rape care services delivery during this workshop. The considerations made for delivering each aspect of the standard of care are outlined as summarised below in box 7.1.

Box 7.1 Expanded standard of care for post rape services

1. Physical examination, specimen collection, analysis and documentation

- Examination and documentation should include establishing the background of the survivors, taking the history of the occurrence, medical history, a full body physical examination (taking note of all bruises, abrasions, teeth marks and cuts). A government-approved documentation form, which is admissible as evidence in court, should be used. The examination should cause minimum stress and trauma.
- Specimen collected includes torn or soiled clothing, a vaginal, anal or oral swab as well as any depositions on the body of the survivor. All these should be packaged, clearly labelled with a date, time of collection, destination and signature of the person undertaking the examination.
- Any specimen or notes that are handed over to another party are to be signed for and a copy kept in the health facility. 2

2. Clinical management and preventive therapies: some survivors will require treatment or surgery for physical injuries. Preventive therapy should be considered for all survivors

- *Post Exposure Prophylaxis (PEP)* should be given as routine to all survivors of rape, in high prevalence settings. PEP must be initiated as soon as possible within 72 hours. It should be given as a priority and should be available at the point of entry to the health facility.
- *Emergency contraception (EC)* should be offered to all female survivors who are not pregnant, not covered by a reliable form of contraception, and who show signs of secondary sexual characteristics. Where dedicated EC drugs are not available, combinations of oral contraceptive pills should be offered.
- *Prevention of sexually transmitted infections (STIs)* excluding HIV: The same antibiotics as recommended for syndromic management can be given. Where a high vaginal swab is taken, it should be primarily for medico-legal purposes. People with 'normal' vaginal swabs should still be offered STI prophylaxis.

3. Counselling is the cornerstone of post-rape care and on-going counselling sessions should coincide with clinical appointments to reduce client visits and increase discussions on PEP.

- *Crisis and trauma prevention:* Counselling should be client-centred and attempt to reduce immediate rape trauma and long-term post-traumatic stress disorder.
- *HIV testing:* Counselling should aim to prepare the client for HIV testing and the results. Previous risk, the window period and the possibilities of HIV infection even when on PEP should be addressed. Post test counselling should cover risk reduction strategies such as use of condoms while on PEP.
- *PEP adherence:* The common side effects of PEP are very similar to those of trauma following rape and may include nausea, vomiting, malaise and aches.
- *Preparing clients for the justice system:* The survivor has the right to make an informed decision about whether or not to report a rape. The counsellor can encourage reporting, provide information on client rights and responsibilities and provide support to clients undergoing the litigation process. However, there are many barriers to reporting rape and conviction rates remain low

7.2.1 Clinical evaluation and legal documentation

Physical examination, evidence collection and specimen analysis included:

- Forensic examination is ideal and recommended for sexual violence survivors. Given the low capacity for forensic tests and examinations due to limited laboratories in Kenya (3.9), physical examination was recommended.
- Physical examination included an external body examination of head and face, arms, torso, legs and feet for any bruises, lacerations and inflammations that could form corroborative evidence. An internal examination focused on the perineum, including a speculum examination for documentation of any internal injuries and a high vaginal swab for analysis in the laboratory. Where anal penetration was reported, an anal swab took priority over a vaginal swab to avoid cross-contamination, and an oral swab was recommended where need be. A checklist for examination and documentation was developed (annex 11) and laminated by LVCT and placed at the points of presentation (casualty, out-patient department, or the HIV care clinic) in each health facility (the rationale for the different points of presentations.
- It was expected that this examination and subsequent documentation would strengthen the presence of corroborative evidence available to the justice system, in addition to institutionalising appropriate documentation.

The checklist also captured information that the clinician should obtain from the survivor including personal history of the client, history of the occurrence, significant medical history, reporting details and emergency management.

- During the first year of the study, documentation of history and injuries for evidence was recorded in the patient cards provided for each patient as part of the regular health system. Through regular monitoring with health providers, provided as part of the ongoing consultations (6.4) it became apparent that clinicians found the time needed to write narratives of evidence challenging as they had long queues of patients to see. It was suggested that a form be designed that acted as both a guiding checklist and a documentation tool. A tool (the PRC1 form is part of the National Guidelines that form an independent attachment 1 to this thesis) was developed though the study period,

used to inform policy and eventually adapted by the MoH in Kenya (chapter 9). During the life of the study, patient cards continued to be used for documentation.

- Police officers would no longer be allowed into the room during physical examination owing to the potential for trauma on survivors

7.2.2 Clinical management

Established medical protocols for management of physical injuries were adhered to. Additional issues raised during the workshop included:

- Where possible children would be treated under anaesthesia. This however remained inconsistent through out the project period due to challenges in access to medical officers to undertake these examinations, and sometimes based on the judgement of examining clinicians who did not feel the need to refer to physicians. In addition, there were cost constraints of acquiring speculums for use with child survivors.
- A vaginal wash with an appropriate antiseptic was recommended AFTER collection of all required specimen aimed at reducing chances of infection due to continued interaction between any pathogens and the vaginal mucosal lining or skin. This responded to the issues of 'vaginal washing' (5.6.2) raised during focus group discussions and was discussed during health provider training (7.3).
- Referral or/and consultation with gynaecologist, surgeons or other qualified personnel was done for high vaginal vault, anal and oral tears and 3rd/4th degree perineal injuries, and confirmed or suspected perforation and intra-abdominal injuries.

The national recommended drugs for broad spectrum STI management were given routinely as prophylaxis to all survivors, through the STI clinics available in each health facility (table 3.3). Considerations were based on literature that identified, on the one hand, the potential for increased trauma and client losses if requirements were made to undertake baseline and two week screening of survivors, and on the other, the prophylactic and treatment value of a combination of anti-biotic drugs in managing pre-existing and empirically treating any acquired STIs post sexual violence (2.5.2).

HIV PEP was provided by LVCT to the health facilities and given routinely to all survivors of sexual violence who presented within 72 hours and were tested HIV negative at baseline. The

72 hour time limit was drawn from literature (2.5.2). It was hoped that this would strengthen access given the distance and transport cost challenges faced by communities, factors that could potentially increase injury-to-door time for survivors. The requirement for HIV negative status was based on the potential for development of resistance to future anti-retroviral treatment if full courses were given to HIV positive persons and the resource implications for delivery of drugs to persons that did not need the drugs.

- Start doses of PEP were availed at the points of presentation in each health facility and initiated during examination. It was at the different points of presentation (where survivors were expected to be first seen once they presented to the health facility) that emergency management was given.
- Up to 6 doses of PEP were commenced, for up to 3 days before the requisite baseline HIV test. This was based on practical considerations of the lack of HIV pre and post test counselling on a 24hour basis at health facilities. Given the implications of the issues at the nexus of disclosure of sexual violence and HIV status, it was felt there was a need for survivors to have some time for processing and decision making for HIV testing if they required.
- PEP regimens for adults included two analogue nucleoside reverse transcriptase inhibitors (NRTIs), a combination of either zidovudine and lamivudine (AZT/3TC) or stavudine and lamivudine (D4T/3TC) in one tablet/capsule given twice a day for 28 days, in line with National Guidelines for ART (3.8.3). Additional considerations for a third drugs included, the potential for reduced adherence, the increased cost of an additional drug that would have policy implications if the project were considered for scale up, ease of administration of two vis-a-vis three drugs and the availability of drugs from NASCOP. The cost of an additional protease inhibitor (PI) at the time (2003) was 50% higher than the cost of a combination of two NRTIs. Plans for scaling-up of ART in Kenya at the time indicated availability of these NRTI combinations through the Global Fund for TB, AIDS and Malaria (GFTAM), thus creating opportunities for tapping into the national ART programme for PEP provision.
- Paediatric PEP regimes were similar to those of adults. They were calculated according to weight bands. Syrup formulations were not used for children owing to lack of availability, prohibitive cost, and storage requirements such as refrigeration that were unsuitable in Kenya[315].

- Where multiple penetrations and/or perpetrators and extensive internal injuries were present, triple therapy PEP was recommended based on the strength of theoretical rationale for increased efficacy[316].

HIV serology was done at baseline and at 4 weeks. In Thika, haematological and hepatic toxicity were monitored at 2 weeks for the first 100 clients. This was reviewed based on suggestions that the duration for PEP uptake only shows anecdotal evidence of hepatic toxicity and there were increased costs of these tests (this cost burden was borne by the health facility - table 7.2) due to additional laboratory tests. However, a baseline haemoglobin test remained as a requirement. Survivors who tested HIV positive at baseline were not initiated or continued on PEP and were referred to the HIV care clinic.

Emergency contraception was provided routinely for all female survivors of child bearing age, who showed signs of secondary sexual characteristics or precocious puberty and were not on a reliable form of contraception. Where dedicated EC drugs were not available, a combination of oral contraceptive pills was recommended based on national provisions for emergency contraception available at family planning clinics at health facilities. Progesterone only EC dedicated pills provided were POSTINOR II and these were availed at the points of presentation due to time constraints (at the time 72 hours was the recommended time limit for initiation).

7.2.3 Counselling services

The development of the counselling protocol was informed by literature (2.5.4), the debates of SV in Kenya and social perspectives that emerged from findings in chapter 5 (5.8). The protocol was designed to take between 1 and 1½ hours on the first visit with four follow up sessions. This was arrived at by examining a variety of factors: existing protocols for trauma counselling following rape that provided a basis for designing the approaches for immediate support to survivors, the need for HIV pre and post test counselling as part of the session, the need for PEP adherence as part of the session for those who were continued on PEP and the need for effective referral to HIV care for those who were HIV positive at baseline.

The following subsections falsely present the protocol as made up of four distinct parts, while in reality they are interconnected and mutually reinforcing. An independent attachment (attachment 2) to this thesis is a booklet that details the counselling protocol in its full form.

Table 7.1 A summarised post rape care counselling protocol developed

Protocol	Content
Contracting with the client	Introduce self, establish client reasons for coming, (where rape is reason establish whether they have received emergency care) Contract with the client (counsellor role, time, shared confidentiality, possibility of separation where client is accompanied)
Supporting the client through rape trauma	Provide core conditions (unconditional positive regard[139]) Explore with client their issues, concerns and fears (based on their trauma) Provide support and address issues raised by clients
Information giving	On health and legal services and the purposes for all of the different requirements On preventive therapies (PEP, EC, STI prevention - required tests, drugs) and discuss their implications including client ability to take the drugs and the expected challenges - personal, with the family, social, professional Legal issues (termination of pregnancy, litigation, reporting requirements and procedures, survivor rights and responsibilities) Contracting on counselling schedule and follow up sessions
HIV pre-test counselling	Risk assessment and risk reduction: consider client age & implications for parents HIV status, window period with regard to consensual sex Client concerns with undertaking HIV test Meaning and implications of HIV test result in the context of sexual violence Disclosure of sexual violence and of HIV test Review client understanding and meanings made of HIV testing, laboratory processes, legal procedures and medical requirements
HIV testing	Refer for HIV test (signed consent and refer client to laboratory) Results are brought back to the counsellor for post test counselling
Post HIV test counselling	HIV negative and HIV positive result Re-contract, assess client readiness for result, give results Result implications, risk reduction counselling Disclosure of sexual violence, HIV testing and HIV status Legal issues, challenge and appropriate referrals For HIV negative results include PEP adherence counselling For HIV positive results include positive living and referral for HIV care Plan of Action based on client empowerment needs for review at the next sessions
On going counselling ****4 more sessions** ****to coincide with clinical follow up**	Introduction and contracting Exploration - issues, concerns, fears emerging from trauma, family and social contexts, legal interactions, medication adherence and follow up, disclosure and risk reduction

The protocol was designed to take advantage of the period immediately post trauma as this timeframe coincides with the initial requirement for HIV testing. Supporting clients through initial trauma was rationalised as necessary for facilitating informed consent for HIV testing and better understanding of PEP information.

Counselling was drawn from the humanistic theory (2.5.4) that recognises individual people's abilities to make decisions given their varied circumstances. The model developed was focused on empathy induction aimed at restoring feelings of confidence and self-worth in the survivor (2.5.4). Counsellors offered high levels of support through attending and listening in contrast to information seeking through questioning. The individual framework for counselling was complemented by encouraging unaccompanied survivors to bring family or friends for support at future sessions. This was based on the understanding that influences on the survivor including self-blame, stigma and discrimination were located social and contexts (2.6; 5.8). Parents, family and friends accompanying survivors were counselled by exploring their feelings towards the occurrence, towards the survivor and towards themselves. This recognised that family and friends are subject to social and gendered constructions of stigma and blame and thus may not support the survivor but instead may become constitutive parts of stigma reproduction (2.5.4; 2.6; 5.8).

HIV pre and post test counselling was informed by an understanding of the need for counselling for HIV testing. It was designed based on the HIV VCT counselling protocols. In addition, the VCT model meant that infrastructure for HIV testing, trained specialist counsellors, distribution systems for HIV testing equipment and quality assurance mechanisms including counselling support supervision for counsellors (3.8.1) were in place and thus provided an opportunity for use of established systems. The challenge of using the VCT model was seen as its focus on achieving behaviour change as an outcome of the counselling process, while our primary aim was trauma recovery. We adjusted the counselling protocol so that the counsellor did not challenge the sexual behaviour of the client. We rationalised that questioning client sexual behaviour could potentially reinforce self blame, thus opted to provide high levels of support through the risk assessment and risk reduction process.

Pre-test counselling included sexual risk assessment of the survivor prior to the violence incident in order to address the possibilities of pre-existing HIV infection. It was informed by concerns of the survivor being in the 'window period', and/or possibilities of sero-conversion during PEP uptake. Discussions on the pathogenesis of HIV transmission in order to develop client understanding of the differences between pre-existing and post sexual assault HIV infection were undertaken, informed by literature that suggests increased adherence to HIV HAART when patients are better informed (2.5.2). The counsellor and survivor explored the implications of the HIV test results on the self of the client, their family, their social and institutional setting. These processes also allowed for initiation of discussions on disclosure of both sexual violence and of HIV status and for exploration of social support options. Readiness to take a HIV test was assessed by the counsellor, who then sent the survivor to the laboratory.

Post HIV test counselling included delivery of results and exploration of survivor feelings and concerns with regard to the results, thus providing the counsellor an opportunity to pick out key issues that could potentially influence PEP uptake or uptake of HIV/ART care services. Issues of disclosure of both sexual violence and HIV status and social support were revisited and discussed in depth. Survivors were encouraged to present with a family member or friend in future sessions.

HIV PEP adherence counselling was borrowed from existing ART adherence counselling frameworks based on cognitive-behavioural models (2.5.4), that seek to inform while achieving a goal of behaviour adjustment (in this case to adhere to PEP).

- Information was provided on HIV PEP, the type of drugs, their nature of functioning informed by literature that positively associates knowledge of HIV and medication with higher levels of adherence to HAART.
- Parents/guardians of child survivors were counselled post test and for PEP adherence. Where the survivor was accompanied, the company was enrolled into the PEP adherence process.
- The limitations of PEP with regard to efficacy were discussed. Possibilities for sero-conversion were stressed and discussions with the survivor or guardian on the implications of sero-conversion even with PEP were initiated. Cognisance was given to

concerns of the possibilities of transmission of HIV to partners for those survivors who remain sexually active during PEP medication. While literature associates belief in medication efficacy with increased adherence to HAART, it was necessary for survivors to be given precise information on the limitations of PEP efficacy (2.5.3).

- Exploration of the understanding of survivors/guardians of HIV anti-retrovirals, including myths that were held was undertaken with a view to providing accurate information.

7.2.4 Systems for services delivery

A simple 'post rape care systems' algorithm was developed (figure 7.2). It linked the different points of services delivery in a systematic manner within each health system to ensure the provision of a package of post rape care services that comprised the standard of care. There were variations due to the geographic layout and functioning of each health facility in the way these services were offered. However, the client flow was similar for all three health facilities. In order of service delivery, it included: *the point of presentation* (where clients would be directed for emergency management when they arrived at the health facility) and was different for each health facility, *the counselling services, the laboratory services, the HIV care clinic.* Two week follow up was done at both counselling at the HIV clinic and four week follow up also included a visit to the laboratory for HIV serology. To ease the challenges of queuing, survivors had the term PEP written at the right hand corner of their patient cards, and this allowed them priority access to services at the different points of the system.

Figure 7.2 Post rape care services algorithm developed

At each point of presentation, the following were availed.

- Initial doses of PEP used to initiate medication
- Full dose of emergency contraception

At the point of presentation in all health facilities, these were locked in the drugs cupboard whose keys were kept in the custody of the nursing officer or clinician on duty. The drugs were entered into the drugs daily handover records. In addition, checklists (annex 10) for physical examination and documentation were placed on walls of the rooms.

In order to ensure that survivors were captured as they entered the health system a register was placed at the casualty. This comprised a hard covered ruled paper book, with columns drawn manually as this is locally available and affordable. Information collected is outlined in section 4.5 of the methodology and annex 6. The rationale for the register was based on the need for: records of survivors seen, identifier information on the survivor, information that would allow calculation of injury-to-door and to-dose time for purposes of initiating PEP and EC, records for the evidence change and to facilitate referrals. Legal documentation after examination would be recorded in the patient cards, with clinicians following the checklist provided (annex 10).

In order to strengthen documentation and the chain of custody of evidence this register had columns for documenting the nature of evidence taken, the police number (personal identification number given to all law enforcement officers that they are required to display while on duty) and for the signature of the police officer who took away evidence (annex 6). The development of a complete chain of custody of evidence fell outside of the objectives of this study. However, services related to the integrity of the evidence chain that were required of the health facility as part of care (examination, evidence collection, legal documentation and analysis at the health facility level) were undertaken.

Costs for survivors were waived in all three health facilities. The treatment burden for items and services that are normally charged was divided in the following way between LVCT and the health facilities with an aim to ensure minimum costs to survivors.

Table 7.2 Costs of post rape care services to LVCT, health facilities and survivors

Service	Thika	Malindi	Rachuonyo	LVCT	
Patient card					Was bought by the survivor in all health facilities
HIV PEP				√	For all 3 health facilities
EC				√	For all 3 health facilities
STI drugs	√	√	√		Through the national STI programme
HIV testing	√	√	√		HIV test kits were available at each health facility through NASCOP HIV prevention and care programmes
Hb tests	√	√	√*		*Funding was provided to buy initial necessary lab reagents
Counselling services				√	For all 3 health facilities

Where a survivor was unable to afford money to pay for the registration card, they were given a waiver through the existing waiver systems in each of the health facilities.

7.3 Capacity building and training health service providers

Capacity building for health workers allows systematic improvement of service management and delivery while helping existing systems work together. Thus the considerations for training programmes (4.4) aimed to improve quality of care and strengthen services within already functional systems. The focus on use of existing systems was based on considerations in literature (2.8.2) including the type and complexity of skill required and support for its acquisition in relation to what was available. Gender mainstreaming was considered fundamental. However, given the lack of tools, I applied integrated gender perspectives drawn from the findings in chapter 5 in the training programmes (7.2; table 7.3). The two distinct training programmes designed at the beginning of the study were aimed at building capacity of two categories of service providers who directly provide services. These included clinical staff (doctors, clinical officers, nurses and laboratory staff) and counsellors. During the course of the implementation, I identified the need for an additional training aimed at orienting all health staff in each health facility. This is described further in section 6.3.3.

Each of the training programme's content, method of delivery and practical considerations spoke to the three key issues identified in the methodology (4.5): what needs to be learnt? How best can learning be undertaken? Can this be delivered? What are the practical implications? In addressing these issues and designing training programmes, the challenges noted in capacities of health providers (3.8.3), literature on gender debates on institutional level influences on services delivery (2.7.3) and, literature on considerations for policy and programming responses for sexual violence (2.8) were called on. Findings in chapter 5 were key to the design of the training programmes. The following sub-sections outline the training programmes that are framed within the standard of care.

7.3.1 Training clinicians, nurses and laboratory staff

I designed the training with support of Dr. Miriam Taegtmeyer (Director LVCT), Dr. Collin Speight (the HIV care manager) and, Dr. Emily Rogena (a forensic pathologist with the Kenya Medical Association and involved in sexual violence forensic work in Kenya). The target group for the training was clinicians, nurses and laboratory personnel involved in front line delivery of post rape care services at health facilities. It was acknowledged that these groups of staff were already trained in providing various aspects of post rape care including some form of examination, attention to physical trauma (6.3). Thus, the skill type required was not new, nor complicated. It was rationalised that in the longer term, training for clinical staff could be scaled up through DRH supervision and training teams (3.8.3), thus increasing service delivery gains in the health system.

The target group were sourced from the health facility points of presentation, the laboratory services and the HIV care clinics. Staff selection for training was done by the hospital management in consultation with LVCT. A three day programme was developed and carried out in each district hospital. While it is acknowledged that gender training would require more time than one morning in a training session, there were practical time and availability constraints for health workers. The key objectives for the training programme are outlined in box 7.2.

Box 7.2 Objectives of the training programme for clinicians

- Develop an understanding of legal concepts and requirements in provision of care for sexual violence survivors
- To review forensic examination, specimen collection and analysis and documentation procedures and protocols in cases of sexual violence
- To understand the clinical evaluation and management for comprehensive sexual violence care including PEP, EC, STIs etc
- To review the client flow and referral systems for provision of comprehensive post rape care services in each health facility

Table 7.3 below outlines the course content and the rationale for inclusion of these sections. Considerations made for each of the different parts of the training programme are outlined below the table. While the table outlines these components as disconnected they overlap and interweave to form one training programme.

Table 7.3 Content and rationale for the training programme for clinical health care providers

Training content	Rationale
Gender and Sexual Violence:	
Local understandings of gender and related terms such as sexuality, sex, gender equity and equality, gender stereotypes, gender power relations and the linkages to sexual violence	Need for health provider understanding of the gendered nature and context of sexual violence informed by gender debates and feminist works (2.4; 2.6; 2.7.2), by the Kenyan debates (3.4; 3.6). These provided a basis for understanding concerns influencing access and uptake of post rape care services for majority of survivors who are women. Need to provide a basis for a renewed lens for evaluating and re-defining gender responsive health sector responses as summarised in section 5.8.
Service provider awareness, attitudes and values towards sexual violence and survivors and their potential implications for services delivery and uptake	Need to understand implications of, and therefore examine health provider attitudes and values with regard to sexual violence informed by literature (2.7.2) and findings in 5.7. For instance: influences of perceptions and values, on history taking and examination given that clients may have challenges with discussing the occurrence, on quality of services offered to survivors based on their form of dress, the circumstances of the incident, survivor-perpetrator relationship (5.8)
The criminal nature of sexual violence	Need for health provider understanding of sexual violence as a crime regardless of the circumstances of its occurrence and the role and responsibility of health sector in enabling justice and thus prevention. This also aimed to respond to existing normalisation of sexual violence (5.9).
Clinical evaluation and documentation:	
Local understandings of the law with regard to sexual violence with an aim to develop a common understanding	Develop a common understanding of the law with regard to sexual violence and health provider awareness of the distinctions between legal and local understandings.
The importance of, and how to undertake forensic examination, evidence collection and preservation and specimen analysis	Need for the technical skill to deliver these services
The importance of and rationale for the accurate documentation that could be used as evidence	Need for health provider understanding of the centrality of acute health care to delivery of justice and thus prevention
Linkages between health delivery and law in the context of sexual violence as the basis for clinical evaluation	Need to understand the inter-sections and between law and health care in sexual violence and their implications for the service provider.

Training content	Rationale
Clinical management	
PEP indication, management and evaluation	Need for health provider knowledge on the mechanisms of PEP functionality to inform PEP administration and management of survivors. This section was largely informed by literature on PEP (2.5.1-4), and findings in 5.9 that highlighted gaps in health provider knowledge of HIV prevention. It included information on the pathogenesis and risk of HIV transmission in the context of SV, what PEP is, rationale for routine PEP provision, eligibility criteria for PEP prescription, drug interactions, efficacy & toxicity concerns, side effects, baseline investigations, & their interactions with rape trauma syndrome, broader issues of access to PEP- for occupational, and consensual sexual exposure, public health implications for PEP delivery
Emergency Contraception	Need for health provider knowledge on the risks and effects of pregnancy in the context of sexual violence, rationale for routine prescription of EC, pregnancy tests/testing, eligibility criteria for EC, side effects and, recommended drugs (2.5.3)
STI - prophylaxis/treatment	With understanding that STIs treatment is part of normal health care services, information focused on the rationale for STI drugs administration as prophylactic treatment without prior requirement for internal screening (2.5.2; 3.9.2). Additional information included, risks of STI transmission, common STIs in Kenya
Counselling	
Trauma post sexual violence and rationale for counselling survivors as a key part of sexual violence care	Need for health provider awareness of the traumatic nature of sexual violence, the necessity of counselling as an integral part of health care. This responds to literature (2.8.4) that clinical care and counselling are complementary. Health provider understanding of the rationale for counselling was theorised as having the capacity to improve overall services including referral mechanisms. It was necessary to impart knowledge on the potential implications of counselling (or lack of it) for clinical outcomes.
Types of counselling required	
Intersections between counselling and clinical care	
Client flow and referral systems (algorithm)	
The importance of, and how to collect and maintain records, and utilise various forms of data	Need for health provider to maintain proper records for data that could be used for planning purposes
The post rape care algorithm (client flow mechanism) as developed in consultation with health management teams	Health provider awareness of the systems for service delivery was central to the delivery of the package of services
The potential challenges and concerns for implementation of the programme - clinical evaluation, care, counselling and referral mechanisms	Given the different circumstances in each health facility, there was need for providers to explore their potential challenges during implementation - logistics, capacities and availability of services to devise appropriate case specific response strategies as these would determine services delivery

7.3.2 Training Trauma Counsellors

A three month programme was designed in three phases with support of Jane Thiomi and Youniter Mutsungah (both of the Supervision and Quality Assurance Departments) and Prince Bahati (Training Manager) at LVCT. This programme was highly experiential for trainees, and was modelled on humanistic counselling theories that recognise human ability to positively cope with situations in their lives, and to make informed decisions for their own good, given presenting circumstances (2.5.4). This was in cognisance of the personal and social challenges that survivors are faced with in making, often difficult decisions of uptake of services, disclosure and readjustment, post sexual violence recovery as seen in the findings in chapter 5. The programme also borrowed from VCT services with techniques that allowed survivors to develop a plan for the future with the underlying purposes of enhancing disclosure, PEP adherence and reporting.

The skill type and complexity required specialised training (2.8). Thus, it was imperative that trained counsellors were already practicing counsellors for whom additional skill was provided. This served three purposes, a) the highly traumatic nature of sexual violence required persons with existing skills in counselling, b) it required less resources in technical and financial input and, c) it served to build onto existing infrastructure by providing an additional skill for already practicing counsellors thus serving to make counselling for sexual violence survivors an integral part of counselling services at health facility. This latter rationale also aimed to reduce logistical challenges of having counsellors trained to provide only one service as this has been identified as problematic in literature 2.8.2, and thus served to integrate post rape care as a horizontal programme vis-a-vis a vertical programme. VCT counsellors were given priority as they had prior training in HIV counselling and testing. Counsellors were certified after fulfilling all course requirements.

The training had 3 phases spaced out over 3 months. This choice was based on the need:

- to provide knowledge and build skills in trauma counselling in the context of sexual violence
- for adequate practice time for counsellor trainees by providing counselling to survivors as part of training with observation and support supervision from experienced counsellors
- to have an opportunity to review, reflect and learn from on these training experiences

Time and staffing constraints did not allow health providers to leave their workstations for long periods of time, hence the 3 phased design. The phases included: one week in residential class, seven weeks in practise where trainees attended to actual clients in their respective health facilities, while under observation, as part of their day to day health care delivery and, another one week in residential training.

The overall aim of the training programme was to equip counsellors with adequate knowledge and skill to effectively provide counselling support to survivors of sexual violence through trauma, HIV testing in the context of sexual violence, adherence to PEP and prepare them for the justice system. The objectives for each of the phases are outlined in box :

Box 7.3 Objectives of the counsellor training programme

Phase 1:

1. Develop a common understanding of gender and sexuality issues and their interactions with sexual violence
2. Develop an awareness of personal values, gendered belief and attitudes and their influences on service delivery for survivors
3. Develop skill in communicating accurate information and providing essential counselling support to survivors of sexual violence in this highly traumatic period for survivors
4. Develop knowledge and understanding of the medico-legal issues surrounding sexual violence and the referral mechanisms for service delivery in each health facility

Phase 2

1. Develop the skills and awareness of participants in dealing with and reflecting on the complexity of real counselling issues for survivors within local contexts
2. Equip participants with the capacity to support survivors through the health and justice systems and maintain the necessary required records

Phase 3

1. Provide participants with an opportunity to evaluate their practice, establish their strengths, and areas of weakness and explore the opportunities available at their disposal (as persons and within the institution)
2. Provide participants with the opportunity to: -
   - Explore the challenges faced in seeing survivors
   - Review, reflect on and analyse experiences for lessons learnt, professional and personal implications for the counsellor
   - Draw in-depth understanding of issues and challenges in the provision of care
3. Learn and practice advanced counselling skills needed for rape trauma counselling, deepen self awareness on emerging issues of participant socialisation and sexuality
4. Facilitate information exchange, sharing and cross learning by participants from each other, while offering a support environment for supervision and counselling

7.3.3 Orientation training programmes for all health providers in health facilities

In June 2004, the need to provide information for all staff in all the health facilities was identified from regular monitoring activities. A four hour training programme was developed in June 2004, in response to the need to orientate a high number of health providers in the health facility and the district on post-rape care services. Sensitisation of all staff in health facilities was premised on the rationale that it would improve communication, referrals within the health facility, local coordination and ownership of the service. The

training requirements conformed to those for continuous medical education in Kenya. The training was modelled on the programme developed for clinical staff. It differed in its methods of delivery. Due to the short periods of training time, there was limited attention to exploration of attitudes and values with a focus on information provision. It was simplified to the level that it could be used to orient a spectrum of health providers from nurses, to other health providing technical staff such as public health technicians, health administrative staff, auxiliary and support staff.

The 4 hour design was based on discussions I held with health providers during regular monitoring. It took into account the logistical, time and financial implications of providing training to all health workers in each facility. The programme was delivered at each health facility so that staff could be available for any emergencies. Often it was designed so that over a period of 3 days health providers from the different sections of the health facility were available in two shifts every day, one group in the morning (normally 08.30 - 12.30hours) and another in the afternoon (normally 13.30 - 17.30hours). This allowed the trainers to maximise on the time spent at the health facility.

7.4 The process of developing post rape care services

7.4.1 Delivery of the standard of care

At the beginning of the study, during monitoring visits some front line officers (clinicians and counsellors) providing services felt that this service was extra work. The implications of the long-term effects of sexual violence for the health sector were discussed with front line health providers as a strategy to divert attention to the longer term benefits of care provided to survivors when they present. The need for a national reference and standards for services delivery was identified by health providers and managers in all the health facilities as critical for institutionalising post rape care services.

Each health facility identified its points of presentation that were different because of the varied physical lay-out and broader service delivery organization in each of the facilities.

Thika: The HIV clinic is housed in the same building as the VCT site in Thika, thus providing an ideal opportunity to reduce client losses in referral pathways. Its operational times 0800-1700hours required that another place be identified to provide emergency care for survivors presenting outside these hours. The casualty thus provided as the point of presentation between 1700 and 0800hours. Only emergency management (clinical evaluation and documentation, provision of EC and PEP) were provided at the casualty. Survivors were referred to the counselling service thereafter.

Malindi: The casualty centre for Malindi District Hospital is closed between 0800 and 1700 hours due to staff shortages and all casualties/emergencies/non-ambulatory patients are attended by health providers also attending to outpatients. The out-patient department was therefore identified as the point of presentation at these times, while emergency management was provided at casualty between 1700 and 0800hours.

Rachuonyo: Out-patient and casualty services are run from the same place due to the limited infrastructure available at Rachuonyo district hospital thus this was the point of presentation for survivors on a 24hour basis.

There were initial challenges for provision of STI drugs for prophylaxis in Thika and Rachuonyo district hospitals. This was due to the vertical reporting requirements imposed on the STI programmes (3.8.1). This system required that accountability for drugs was based on screening of patients and results of analysis before STIs drugs can be provided. Thus, STI prophylactic/empirical management for survivors was challenging to this established system. The DHMT in Malindi District Hospital altered these requirements. This allowed me to prompt and have discussions with DHMTs in Thika and Rachuonyo and they began to give STI drugs to survivors of sexual violence in July and August 2004 respectively. Fears of the use of PEP as an 'after-morning' pill for unprotected sex were expressed. It was agreed that PEP would be provided in cases of occupational exposure for health workers in the district and for sexual violence exposures.

There were constraints experienced in filling of P3 forms by medical doctors and were partly located outside of the health sector as observed in the findings (6.3). While district health management required medical doctors in the hospital to fill in P3 forms, in how far and the means by which this could be enforced was unclear and therefore not actively followed up in

all the study sites. In addition, unclear pathways for evidence analysis and utilisation by the criminal justice system (outside the scope of this study) meant that there were limitations to finding solutions for this challenge throughout the study period. This study therefore cannot shed light on how many of the survivors got legal support and what role evidence collected has played in prosecution and litigation processes. This has been identified as a key area for future research work. These challenges however informed policy and the development of a form for history taking, documentation of injuries and specimen analysis. At the time of writing this thesis, this form has been approved by the MoH (titled PRC 1, approval number MoH 363).

Protocols for the rape trauma counselling sessions were developed and the first training undertaken between March and July 2004. Participants were drawn from the three district hospitals (2 Thika, 2 Malindi, 2 Rachuonyo and 2 staff members from LVCT). In October 2004, a workshop for experience sharing, feedback and assessment of the protocols was undertaken. The training programme was pre-tested in the second class in February to May 2005. This was updated, evaluated and finalised. This formed the basis of a curriculum that was later adopted by the DRH in Kenya to develop a counsellors training manual described in chapter 9. Emerging challenges, and thus areas of changes, included the importance of differentiating the needs of adult and child survivors.

- The implication of the mother's HIV status where a survivor was aged below 6 years and was HIV positive
- Legal considerations for consent for HIV testing. Counsellors faced challenges when sexually active survivors who were minors presented, and their parents had rights to knowledge of their HIV status.
- There were challenges inherent in the concept of shared confidentiality: to whom information can be shared, the rights of the survivor vis-a-vis those of the counsellor to make decisions on information sharing especially where the counsellor felt the existence of medical rationale for disclosing client information, and with regard to the rights of minors with regard to disclosure of sexual violence and HIV status
- Unaccompanied survivors were encouraged to disclose and bring with them a family member for subsequent clinical and counselling sessions.

Poor referral mechanisms from the lower health facilities were associated with lack of coordinated information delivery to these levels, and cost barriers of access by survivors. Internal referrals were most challenging in Thika where there was separation of diagnostic counselling from VCT in terms of location of service delivery, although the same counsellors provided the services. Thus, while Thika saw the highest number of clients, it also experiences losses in the system and health providers also noted the lack of coordination.

7.4.2 LVCT support to the health facilities

Due to staff shortages, LVCT supports districts through 2 models (1) posting an LVCT staff member for a limited time (whether to do this is discussed with the institution) to work alongside the health facility staff to support establishment of services and strengthen systems, or, (2) pays the health facility to employ a staff member to do regular clinical duties, and have one of the government staff seconded to the programme and given capacity building support by LVCT. The latter is the preferred model as it is assumed to enhance ownership of services.

Thika: LVCT provided a nurse trained in physical examination, specimen collection, documentation and HIV care/ART administration including PEP. Charity Mbugua served to support the development of systems for the PRC programme, and for the HIV care/ART programme that was supported by LVCT in Thika. The effects of this arrangement on the future of the programme are unclear at the time of writing. There were instances in my discussions with health providers when I felt that the PRC programme at Thika was seen as an exclusive and parallel programme. For instance, when Charity Mbugua (the nurse attached to Thika) went on maternity leave (coinciding to the end of the study period), the hospital did not immediately release a clinician/nurse for the care and support centre and thus survivors did not always get services, and some survivors seen were not recorded in the register. On the other hand, this arrangement allowed for faster implementation of systems and better data collection (7.2). There was constant interaction with the DHMT. Charity's presence facilitated enhanced communication and faster addressing of the challenges that emerged during the implementation process.

Malindi: Throughout the study period, there was least direct involvement of LVCT with Malindi. The health management team seconded two clinicians (one male and one female), set out rota for staff to provide support services to the survivors. The ownership and charge

taken by Malindi may be associated with the dynamic nature of the district Medical Officer of Health.

Rachuonyo: LVCT paid the health facility the equivalent of a salary for one clinician and one was assigned to the HIV care/ART clinic. Survivors were not exclusively seen here, but at the OPD (also acting as casualty).

7.4.3 Mobilisation activities

Different strategies were employed for mobilisation activities in each of the study sites. Mobilisation was aimed at enhancing public information on the services offered at the health facility and were based on what was considered by health providers as their most 'effective' strategies. While this has not been evaluated, health worker experiences in mobilisation for immunisation services, for programmes such as polio-elimination and for HIV education and information were called on. For instance when public health workers went on public education campaigns they incorporated post rape care messages into the programmes. Key personnel in each health facility included the District AIDS and STI Control Officer (DASCO), the Public Health Nurse and the Public Health Technician.

Malindi: One day information giving workshops were organised for 3 groups of people:

- Community Based Organisation stakeholder group - all CBOs in Malindi, working within the health sector are organised to meet once every two months through the office of the District Development Officer. We thus took advantage of one of these meetings to provide information on services, and the role of these organisations in supporting presentation by survivors.
- Religious leaders of the different denominations.
- The police (all station in-charges in the district) further discussed below

Rachuonyo: four youth groups using music, plays, skits and puppeteer activities, key in supporting delivery of HIV/AIDS messages were selected by the DASCO and the DMoH. LVCT trained this group using the framework for the 3 day clinicians training, with much less of the health care technical information and more training on attitudes and values that influence sexual violence. They prepared skits, plays and songs that were evaluated by the DASCO, myself, the Public Health Nurse and the MoH. These were carried out during targeted days in the communities.

Thika: there was no targeted mobilisation activity in Thika.

7.4.4 Engagement with local police

In each of the districts, the District Medical officer of Health was assisted in initiating discussions with the officer in charge of the police station nearest to the hospital. While engagement with the police was outside of the scope of the study, the police station was identified as a potential barrier to timely presentation for health care given the delays survivors faced when reporting. These discussions aimed at ensuring survivors were sent to the hospital in the shortest period post-reporting given PEP and EC time considerations.

Thika: 3 meetings were held between 3 representatives appointed by the health management team (the hospital matron, the consultant health facility gynaecologist and myself) and, 1) the Police Officer Commanding Thika Division (OCPD) and 2 senior officers in December 2003 (2 months into implementation), 2) all officers commanding all police stations in March 2004; and the OCPD again in August 2004. The second visit with the OCPD was prompted by health workers who still reported delayed reporting by survivors who presented at the police station. This issue still remains a challenge with Thika District. Efforts to provide a one-day training for a number of police at the station (hoping that with more officers trained, increased levels of awareness may translate to less delays as information trickle-down through top officers may not always get to all officers) during the study period were not fruitful.

Malindi: One meeting was held between the DASCO, the MoH and the OCPD. Subsequently two one-day awareness programmes with police were undertaken in April 2004 (2 months into implementation) and in November 2004.

Rachuonyo: Two meeting were held with the OCPD and the OCS in June 2005 (2 months into implementation) and in August 2005. There was little enthusiasm amongst these officers to train other officers within this police station.

7.4.5 Engagement with DHMTs and MoH

In designing the study, I realised that practical aspects of service delivery such as survivor management and the systems could only be engendered through service provider commitment. I constantly engaged with the DHMT members in each of the health facilities. This facilitated discussions on the most appropriate measures for issues emerging including mobilization activities, engagement with local police and service delivery challenges that have all been described (7.4.1-7.4.4). I also discussed gender concerns with regard to service

delivery being aware of the tendencies for conceptual hegemony by proponents of a gender and health analysis vis-a-vis addressing women's health. At service delivery level, there were more female front-line staff while the training programme for clinicians had more male health providers in each of the training session in each district. This may be a reflection of MoH and broader biomedicine gender in-balanced nature of health provider categorisation. At higher decision making levels and clinical services delivery are male practitioners and females at lower levels associated with care services. The challenge of how to address this situation lies within a context of broader health sector gender related concerns, and is double edged with regard to sexual violence. Improving decision making power so that female nurses, who form the bulk of service providers were able to provide evidence admissible in court would potentially mean additional tasks for them. This is in a context where reforms such as sector wide approaches, are gender blind in programme planning, monitoring and evaluation, focussing on quantifiable indicators such as numbers of health providers trained, over qualifiable indicators necessary to assess gender impact of reforms (2.7). My awareness of these issues did not transform to clear action as they are conceptually and pragmatically difficult to address and also fell beyond the scope of this study.

Thika: The DHMT met monthly and I was able to attend presentations on the post rape care programme. These were often made by the consultant gynaecologist under whom the post rape care programme fell, although he was not a direct implementer. Thika District had 3 MoH's during the study period. This required re-orientation every time a new MoH was on board. The limited involvement of service providers, LVCTs direct human resource and lack of constant management may have negatively impacted on ownership of the programme and limited integration with other activities in the health facility.

Malindi: Had a robust DHMT that met monthly and I made presentations at least once every three months. This may perhaps explain the larger levels of coordination in this facility, ownership of services and the limited need for me to be at the health facility. The integration of the post rape care programme with other programmes such as mobilisation activities was stronger in Malindi, perhaps due to this coordinated approach. In addition, the DMoH of Malindi was keen on having post rape care services thus strengthening implementation. This may explain the greater sense of ownership of the service in Malindi. I utilised the lesson for the need for health manager involvement when seeking to influence the Division of Reproductive Health in policy development (chapter 9).

Rachuonyo: The Medical Superintendent was primarily involved in the post rape care programme. The limited size of the hospital facilitated easier communication among the health workers and I attended DHMT meetings once every three months to be a part of the post rape care discussion. The DASCO led these discussions and was key to supporting mobilisation through community groups as she noted the limited uptake of services. Rachuonyo was however slower in adopting changes to the system such as the utilisation of STI drugs for prophylaxis and appeared to remain more rigid in service delivery. Ownership and commitment for service delivery appeared to be greater than in Thika despite challenges in uptake and perceptions of sexual violence (8.4.2). The engagement of the Medical Superintendent may have enhanced the commitment to service delivery seen in Rachuonyo.

7.5 Positionalities: influences on developing and implementing the intervention strategy

7.5.1 Understanding of gender among the participants

There was little understanding of sexual violence as a gender issue amongst the research teams who did the field work, the health providers themselves and the health managers. In discussions with health providers, sexual violence was often located in a moral framework and was seen as evil, bad, immoral with limited co-relations to broader gender concerns. Training provided conceptual meaning of gender and group work discussions thereafter on the linkages between gender and HIV and sexual violence. Gender issues were unpacked during training and related to health uptake and service delivery. The inherent challenges in this approach are discussed in section 7.6. During all trainings, gender was discussed over lunch break of the first day of the workshop among participants. Often, it was in banter of the term gender, gender equality and affirmative action, by both male and female participants. However, this seems to have changed over the workshop period. For instance, assessment of district health management teams workshop, to the question, what was the most useful part of this workshop? 7 of the 20 respondents indicated either or both 'understanding gender' and 'the links between gender and sexual violence'. During the on-going technical assistance period, I engaged health providers to consistently question and challenge their gendered perceptions. To what extent these approaches may have been transformed to the intervention process is unclear as the assessments were anonymous and Ngugi (2.4.1 [2000][64]) cautions on

the disconnect between understanding how gender roles and relations shape interactions and transforming this understanding into action.

In training gender to the different groups, I drew from radical feminisms and made links between sexual violence and HIV, and patriarchy as a form of political and economic power within our communities. I did not use the word feminism due to its historical connotations in Kenya (3.4), and I focused on the potential impact of ignoring how gender shapes sexual violence. For instance, the patient burden, time and treatment costs of HIV infection post sexual violence given the high risks of transmission. This approach could be challenged for undermining the use of a rights framework in favour of a cause-effect relationship model. While I was clear that I needed to employ strategic frames that allowed me to relate the inequality issues to my constituents who had a bio-medical orientation, I also did not wish to appear overtly feminist (4.8). Given the socio-political resistances to the women's agenda (3.4.1), I felt the need to rationalise my arguments from bio-medical and public health perspectives. However, this balancing act is in itself is problematic in three ways.

First, there was no framing or measurement of the effects of this approach on the health provider attitudes and values, thus is it unclear to what extent this may have been useful as a strategic approach. Insinuations of positive effects can only be made from the interviews that were undertaken on services provision and are discussed in chapter 7.4. Perhaps, with attempts to transform gender responsiveness in health sectors, these training approaches could provide a basis for examining the usefulness of training gender to health providers as an integral part of health provider training.

Secondly, while this approach may be persuasive and conform to the broader African feminist view of cohesion within communities (2.4), the extent to which it reinforces sexual violence through perpetuating existing structures and undermining reporting is questionable. Interactions at individual and community levels are intimately connected to and shape responses for sexual violence (5.8). Examining these interactions as we did in the training sessions, without explicitly challenging them could be argued as contributing towards the normalisation of sexual violence. In addition, while this approach brought to the attention of health providers the biological and social factors, interrogated gender risks, vulnerabilities to

sexual violence, it does not question the gendered organisation of the medical knowledge and systems as a critical part of response.

Third, the non-confrontational and academic approach I took resonates with the movements in Kenya between 1984 and1991. The shift to of the sexual violence debates in Kenya at the time from the public domain of advocacy to academia at the time resulted in fading of public visibility of sexual violence (3.4.2). The work of this thesis did not provide space for oppositional activism that would have provided me an opportunity to actively engage the public discourse through advocacy, an area I had leanings towards. My ability to demand for state accountability for ratified rights instruments was limited by the context of my work that was framed in government health sector and HIV responses.

7.5.2 Intersections between gender, service providers perceptions and service delivery

Participants demonstrated understanding of the social location of sexual violence and the various levels of responses (biological, community and institutional) that exist. The VHA framework and ecological model provided me with a basis with which to structure these examinations with participants. Utilising the ecological model allowed participants to identify factors that influence vulnerability to sexual violence at the local level. Stigma was identified in all groups trained as an effect of sexual violence. However, participants did not view themselves as part of the very same community they saw as perpetuating stigma. For instance, during the training for clinicians and for counsellors one of the exercises included asking participants to write down all feelings, words, descriptions that immediately occurred to them when the heard the words, 1) raped and 2) rapist. With regard to 'raped' three words that appeared in all groups throughout the study period were dirty, shame, sympathy/sorry. However, during discussions, it was clear that there was no initial correlation between participant use of these words and participant own performative process in perpetuating stigma and the potential implications on services delivery. Health providers did not consider their own perceptions as constitutive of their service delivery roles. For instance, to what extent were clinician questions during history taking curious rather than functional? How was this influenced by the survivor-perpetrator relationship? Or the circumstances of the occurrence? Or by gender and age of the survivor? This may be exemplified by one male

clinician from Malindi, who admitted being extremely embarrassed to examine an elderly lady;

> *"she was about my mother's age and she would not provide any history... I asked a nurse to take the history and do the examination... I signed for it"*

During my own training as a rape trauma counsellor, I was confronted with my own values and attitudes. While I was (and still am) convinced that all sexual violence is a crime, sexual violence against children draws stronger sensitivities in me. Perhaps, this has to do with my own undesirable childhood sexual experiences, the clarity of which has increased through the study period. I was less inclined to provide counselling support (during my training period as a counsellor) to girl child survivors than to adults. Relating my experience to broader service delivery, I have been constantly drawn towards examining the issues at the nexus of personal sexual experiences, gendered identities and services delivery. Training, particularly that of counsellors, was used to discuss these issues and service provider awareness and control of them during counselling. The factors, extent and pathways of these influences were not established from this study and still remain unclear.

7.5.3 Health provider ownership of the services

Transformative participation, aimed at strengthening health facility management of their services (4.4.4), meant that district health teams and health providers largely made decisions on the processes for services delivery. Sometimes this contradicted my expectations and closed spaces for engaging gender sensitive issues that were emerging in the study. For instance, in responding to the findings on sexual violence in relationships, and perhaps my gender advocacy leanings, I felt the need for this to be addressed. I brought it to the workshop with DHMT members with an aim to institute screening of violence survivors amongst women patients and offer necessary support services. This idea drew strong resistances, and a general consensus not to address this issue explicitly was arrived at. The rationale for this decision being that the health sector provides a service to all survivors irrespective of the circumstance of the occurrence. I eventually buried the question of sexual violence in relationships in the training programmes, aimed at exploring self-values and attitudes within a context of their influences on services delivery and uptake. The choice not to address some of the issues emerging from participants resonates with varied standpoints in

research. The qualitative researcher paradigm sees study design as contingent to a researcher values and political commitment (2.9). Fine[207] also asserts that researchers weigh what works for them, hiding behind neutrality of representations (4.8.3). I saw these standpoints reflected in my collaboration with both health managers and DRH staff and felt at a loss that opportunities were missed. At the same time, I was glad that health providers were demonstrating ownership of the service.

Chapter 8 Uptake, delivery and acceptability of post rape care services

8.1 Introduction

Findings in this chapter refer to objective 3 of this study, to describe the uptake, delivery and acceptability of post rape care services in three district hospitals in Kenya and are derived from 4.5 of the methodology. These findings are organised into four broad sections. Section 8.2 describes the uptake of services as a result of the interventions implemented by describing profiles and characteristics of presentation. In describing delivery of post rape care services (8.3), I describe coverage (proportions of survivors accessing the standard of care), quality of clinical care, quality of counselling and quality of PEP delivery. I describe acceptability of services (8.4) by health providers outlining awareness, knowledge, opportunities and challenges in the delivery of the standard of care and capacity building intervention. Section 8.5 discusses the implications of the findings and in 8.6, I reflect on the success, issues and challenges.

8.2 Uptake of post rape care services

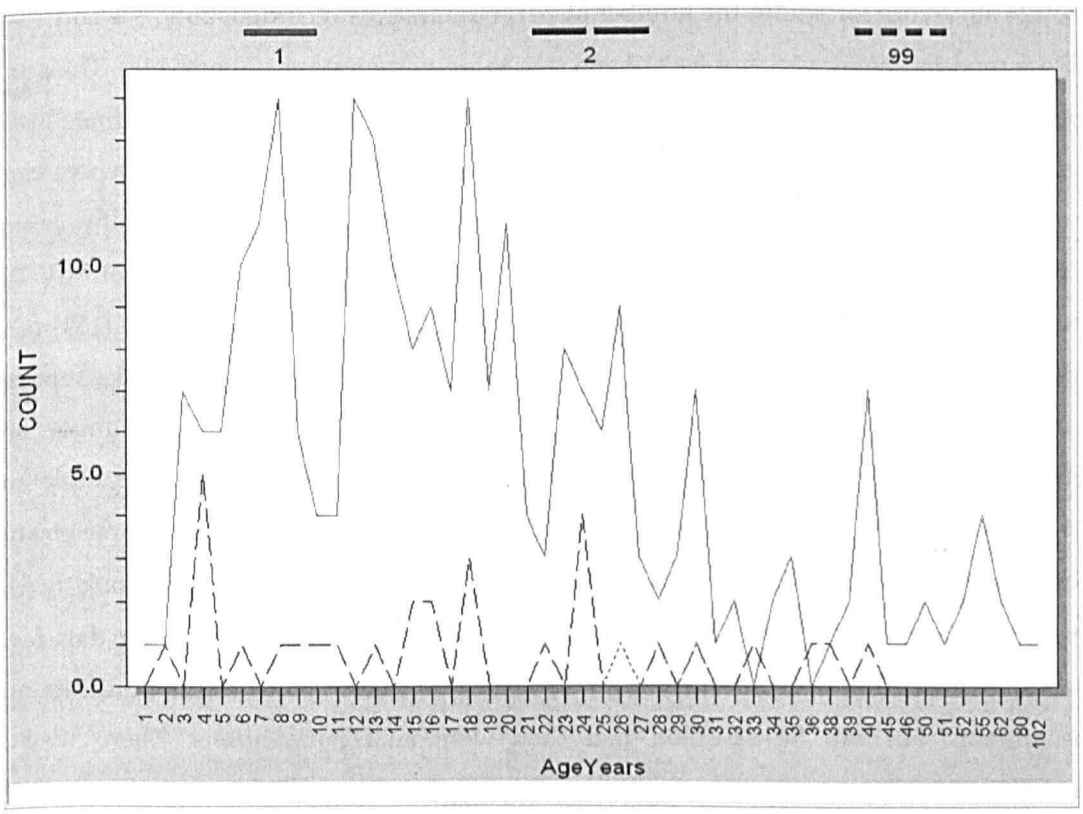
Data collection ran from October 2003 to June 2005 in Thika, Malindi and Rachuonyo. Total facility attendance for this period was 396 survivors of sexual violence, distributed as follows in each of the Districts Thika 267, Malindi 83 and Rachuonyo 46. Of these, 327 were women and 45 were men with 24 records missing sex values.

Of 396 survivors seen, data that were available for analysis were of 295 records. 101 survivor records were excluded from analysis as the data available were poorly and inconsistently documented, a limitation for this study (4.6). Of these 101, 10 survivors did not have records but documentation was on patient cards attached to the register at the HIV clinic and thus there was no information available except date clients were seen, their names and the clinical management given to them. Of the remaining 91 records, documentation on casualty, lab or HIV clinic records was incomplete for the purposes of this study. For instance, there were survivors who were seen at the laboratory but were not captured at any other service delivery

point. Data that did not have at least half the variables documented, or did not have any variable in the following sets of characteristics, demographic, presentation and/or PEP medication were excluded from analysis as they could not be used for purposes of this study. Thus the following analysis reflect 295 records of survivors analysed.

Of 295 survivors seen, the median age of the entire study population was 16.5, Inter-quartile range ([IQR] 9,25) with no significant difference between male and female survivors. The age range for females was 16 months to 102 years and for males ranged between 2 and 40 years of age. 13 records were missing age indications. Of 282 survivors where the age of the survivor was indicated, 56% (164) were children aged 18 years and below; 89% (145) of these were female and 11% (19) were male. This distribution was comparable to that of adult survivors aged (88% female and 10% male).

Figure 8.1 Survivors seen - distribution by age



Key: ——— female; - - - - - male

3% (9) survivors presenting in Thika district hospital were mentally challenged and were all female and one survivor was hearing and speech impaired.

Health providers asked survivors or their guardians/parents whether they knew the perpetrator and if so, if there was any blood relation. However, during analysis it was difficult to distinguish between perpetrators relation to the survivor as there were no clear boundaries of 'blood relation' nor were there operational definitions drawn at the beginning of the study. For instance, where a perpetrator lived in the homestead but was not a brother or sister to anyone in the family, it was difficult to determine. Thus, during analysis the two variables (1 and 2 of Q 15 [annex 9]) were captured as one - known perpetrator. 55% (146) of survivors reported knowing their assailants with no differences by age or district. 64% (105) of children (both boys and girls) were violated by assailants known to them or their guardians/parents.

Of the 124 survivors for whom the number of perpetrators was recorded, 86%, 8% and 3% of survivors reported being violated by 1, 2 and 3 or more perpetrators respectively. The sex of the perpetrator was not documented in this study, but is assumed to have been male for all reports where human penetration was reported. It was only in Thika district where more than one perpetrator was reported by any of the survivors. It was assumed that all survivors seen reported some form of anal or vaginal penetration, due to the prescription of HIV PEP although 40% (120) of the records did not indicate the type of penetration. 61% (159) of all female survivors reported human vaginal penetration. 2 survivors all from Thika reported use of unspecified objects in their vagina, 2 female survivors reported human anal penetration. 1 survivor (2 year old, in Thika, seen in December 2003) reported multiple anal and vaginal penetrations. Of 31 male survivors 10 (32%) reported human anal penetration and one male survivor aged 15 years from Malindi reported penetration by use of objects (that were not specified) in addition to human penetration. This was not captured in the data form, but was documented in the clinical record. The rest of the male records did not indicate type of penetration, but can be assumed that they were anal penetrations. There was no presentation of oral penetrations during this study period.

8.3 Delivery of Post Rape Care services

The objectives were to assess proportions of clients who received the standard of care, as recommended in the algorithm (figure 6.1).

8.3.1 Coverage

Coverage aimed to describe the services received by survivors. Findings show that not all survivors received the standard of care as recommended. Some survivors received some of the services. For each survivor data were extracted from clinical routine records and these data described. Table 8.1 summarises coverage by showing the numbers of eligible survivors receiving the different services.

Table 8.1 Coverage of post rape care services

Coverage		Thika	Malindi	Rachuonyo	Total
Survivors presenting		267	83	36	396
Incomplete records					
Complete Survivor data		**n=261**	**n=20**	**n=13**	**n=295**
Sex:	Female	235	15	11	261 (88%)
	Male	24	5	2	31(11%)
	Missing sex values	2	0	0	2
Age:	</=18 years	145	14	5	164 (56%)
	> 18 years	105	5	6	116 (40%)
	Missing age values	11	1	1	13 (4%)
Disability		9(4%)	0	0	9 (3%)
Perpetrator known		145 (56%)	1(5%)	not indicated	146(50%)
Quality of clinical care		**(n=261)**	**(n=20)**	**(n=13)**	**(n=295)**
Physical examination		142	16	5	163(56%)
STI prophylaxis		198	11	6	215(73%)
Laboratory services		192	15	10	217 (74%)
Emergency contraception (female; >12years; not on contraceptive; <72hours presentation)					
		(n= 92	8	5	105
Quality of counselling		**(n=261)**	**(n=20)**	**(n=13)**	**(n=295)**
Initial counselling		130	4	7	141 (48%)
					(n=141)
f/u counselling at wk1					67
f/u counselling at wk2					83
f/u counselling wk4/6					101
Quality of PEP delivery					
Start doses of PEP (n=250)**		218	18	12	248 (99%)
HIV test at baseline (n=295)		178	19	10	207 (70%)*
PEP continuation (n=194)					180 (93%)
PEP clinical care f/u wk2 (n=194)		115	8	9	132 (68%)
PEP clinical care f/u wk4 (n=194)		85	5	9	99 (51%)
HIV test at week 4/6 (n=194)					67 (34%)

- *207 represents the total who received HIV testing of whom 13 were HIV positive, hence 194 survivors were eligible for PEP continuation
- ** 250 represents the number of survivors who presented <72hours and were thus eligible for PEP

Injury-to-dose time was defined as the time reported between exposure and administration of the first HIV PEP dose. These data were generated by taking the difference recorded time of injury and when PEP was administered. The mean injury to dose time recorded for all sites was 8.31hours with no distinct variations by age or district.

The point of presentation in each health facility was determined by the operating hours. This refers to the first point of service delivery that survivors were seen at and was the casualty or the HIV CCC clinic. This data is presented by district only as there were diverse points identified for presentation during the consultative meetings, hence data could not be applied across the study sites.

Thika:

42% (110) survivors presented at the casualty between 1700 and 0800

22% (59) presented to outpatient department which houses the HIV care clinic and were thus seen during regular working hours

13% (34) presented at VCT, and can be presumed to have primarily been seeking HIV counselling and testing

Table 8.2 Point of presentation data

Point of presentation	Thika (n=261)	Malindi (n=20)	Rachuonyo (n=13)
Casualty	110	5	4
OPD	59		
HIV care		2	
VCT	34		3
Missing data	58	13	6
	261	20	13

Door-to-dose time referred to the duration between when the survivor reported having arrived at the health facility and the time they were provided with their first dose of PEP. In this analysis it was assumed that the point of presentation was the location at which the PEP start dose was provided. Analysis was done by district. The mean door to dose times for Thika, Malindi and Rachuonyo were 2.0 hours, 2.05 hours and 1.5 hours respectively.

(86%) 250 survivors presented within 72 hours of exposure and were thus eligible for HIV PEP start doses and emergency contraception in addition to other services: examination, specimen collection and analysis and legal documentation, STI prophylaxis, laboratory analysis and counselling services. 222 (85%) females and 28 (90%) male survivors presented <72 hours. 83% of survivors in Thika presented within 72 hours as compared to 95% and 93% from Malindi and Rachuonyo respectively. However, this may be attributed to the few records that were analysed from these districts.

8.3.2 Quality of examination and clinical management

Quality of services delivered was described by the number and profile of survivors receiving the standard of care in each service delivery point (4.5; box 7.1).

- *Physical examination and legal documentation* was undertaken by a medical or clinical officer, guided by a checklist (annex 10). Specimen was collected and sent to the laboratory for analysis and the examining officer documented their findings.
- *Start doses of HIV PEP and emergency contraception* were provided after information giving session on HIV testing and pregnancy by the clinician. Consent was requested and these drugs given during the process of initiating examination and documentation and swallowed in the presence of the clinician. Where HIV testing could not be accessed immediately, 3 day doses of HIV PEP were provided and referral to the counselling clinic undertaken.

Table 8.3 Quality of examination and clinical management

Variable	Thika		Malindi		Rachuonyo	
	</=18yrs	>18yrs	</=18yrs	>18yrs	</=18yrs	>18yrs
Missing age indications*	11		1		1	
Physical examination n=164+	85 (59%)	51 (49%)	12 (86%)	4 (80%)	3 (60%)	2 (33%)
HIV PEP start doses (for those presenting <72hrs) n=250	119 (100%)	89 (98%)	13 (93%)	5 (100%)	4 (100%)	6 (100%)
Laboratory services	110 (75%)	73 (70%)	11 (79%)	3 (60%)	3 (60%)	6 (100%)
STI prophylaxis	120 (83%)	67 (64%)	6 (43%)	4 (40%)	3 (60%)	2 (33%)

* The missing age indications meant that these records were not reflected in the age dissagregated analysis reflected in this table.

Fifty six percent (164) of 295 survivors received physical examination at all health facilities. 62% (101) children received examination. 58% (152) of female survivors and 36% (11) male survivors were physically examined on presentation. The collation tool did not adequately reflect the differences in presentation points and thus, it was difficult to determine where physical examination was most likely to be offered in each of the districts. By district, survivors who received physical examination were 54% in Thika, 80% in Malindi and 39% in Rachuonyo.

HIV PEP start doses were provided at the different points-of-presentation in each health facility. 99% of 250 survivors presenting <72hours were given the start dose of HIV PEP in all of the various points of presentation in all health facilities.

There was no lower age definition for delivery of emergency contraception. Clinicians were advised to prescribe for all female children showing signs of precocious puberty if they were not of reproductive age (2.5.3; 6.2.2.4). For the purpose of this analysis I used 12 years as the lower age limit for analysing uptake of emergency contraception, as this is the upper limit of the age of 'medical children'.

178 female survivors aged >12 years presented for services. 150 of these presented <72 hours of exposure, thus were eligible for EC. 8 survivors who were provided with EC were excluded from this analysis (5 had no recording of their time of presentation, 3 presented after 72 hours). Of the 150 eligible survivors, 39 were post menopausal, reported currently being on a form of contraceptive, were pregnant or were on menses and 6 eligible survivors had missing values regarding EC in their records. A total of 105 survivors received EC among whom 8 were excluded from analysis.

91 (82%) of 111 eligible survivors were provided with EC. 20 survivors who were eligible for EC were not provided among them 4 children (<18years). An 82% delivery rate for EC was attained in this study population.

There were 36 missing data. By district, STI prophylaxis drugs were received by 77% (198), 55% (11) and 46% (6) in Thika, Malindi and Rachuonyo respectively. There were no

significant differences in age and sex in the three districts. Though Thika had a large number of survivors whose data were available for analysis, they had the highest number of survivors provided STI prophylaxis.

8.3.3 Quality of counselling

- *Initial counselling was provided at the baseline visit.* It included counselling for trauma, for HIV pre and post test counselling, for PEP adherence and preparation for the criminal justice system.
- *The recommended counselling sessions* included: 1st at baseline, 2nd at week 1, 3rd at week 2, 4th at week 4/6, 5th at week 12. Where a survivor attended at least 3 counselling sessions they were reported as having achieved the standard of care counselling
- During subsequent visits the following were provided, PEP adherence counselling, trauma counselling and on-going support for the survivor and the family, disclosure support.

I did not measure the survivors who may have come for the fifth counselling session as these data were not collected at the VCT site (4.6).

Initial trauma and HIV counselling was offered to 50% (141) of all survivors. 49% (72) were children and/or their parents/guardians. By district, in Malindi counselling was offered to 20% (4) children and their guardians only. It was difficult to distinguish between those who were provided counselling as individuals and those for whom guardians/parents were provided. For some adults, partners/social support were present for counselling and these were sometimes recorded as 'counselling provided to parents/guardians'. It had been envisioned during the questionnaire design that children would be accompanied by their parents/guardians. However, some older children (adolescents) were unaccompanied. Thus, the variables (1 & 2) of the question on counselling were merged. In the following sections, reference is made to 'counselling was provided to..' with no distinction between that provided directly to the client and that provided to other social support.

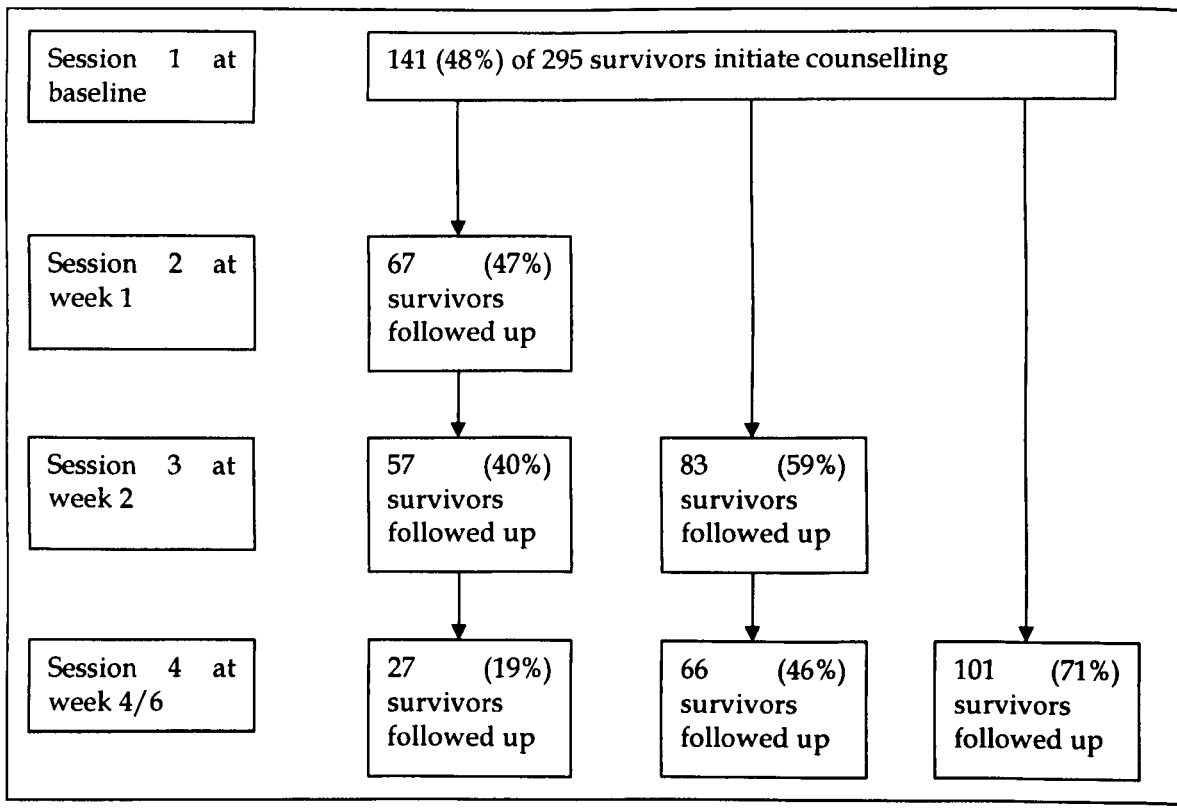
During analysis it was noted that there were survivors who had followed up at 4 weeks and some at 6 weeks. In retrospect, designing the questionnaire to measure both follow up periods presented challenges for retention and follow up at programming level. Thus, these

variables were merged into one variable (follow up at 4 or 6 weeks). There were survivors who visited at both follow up periods, but are only captured once and those that visited at one of these times were also captured once. This is expressed as follow up at week 4/6 in this thesis.

Data shows that 71% (101) survivors of the 141 that initiated trauma counselling were followed up at week 4/6. Not all survivors followed through the protocol to attain 5 sessions of counselling. The following demonstrates survivor follow up through counselling for those who initiated. Figure 8.2 below demonstrates follow up of survivors for counselling.

- 19% survivors were retained for at least 4 consecutive counselling sessions: Of 141 survivors who initiated counselling 47% (67) survivors followed up counselling at week 1, among whom 40% (57) followed up at week 2, and a further 19% (27) at week 4/6. Thus, 19% of survivors who initiated HIV counselling at first visit were followed through at least 4 consecutive sessions of counselling.
- There were survivors who were provided with initial counselling and did not return at week 1 but returned at week 2 and week 4 and thus were retained for 3 counselling sessions. 59% (83) of 141 survivors followed up counselling at week 2, meaning that 26 survivors who did not follow up at week one followed up at week 2. Of these 83, 66 followed up at week 4/6, thus achieving a follow up rate of 46% for at least 3 counselling sessions
- There were survivors who did not follow up at week 1, or 2, but followed up at week 4/6. 71% (101) of survivors followed up at 4/6 weeks.

Figure 8.2 Survivors retained for counselling



Routine laboratory services included analysis of specimen as requested by the clinician and HIV testing. For the purposes of this study, we only recorded whether the survivor had been to the laboratory and if so, whether HIV testing was undertaken.

Seventy four percent (217) survivors had laboratory services delivered to them during their course of treatment. The distribution of laboratory access was similar across the districts. Figure 7.2 describes HIV PEP medication delivery. It documents PEP delivery at presentation, HIV testing through to PEP completion. Seventy-nine per cent (232 [206 female and 26 male]) of all presenting survivors were tested for HIV at baseline. 15% (45) of all survivors did not undertake HIV testing at baseline either because they were not offered, or they declined thus missing opportunities for HIV testing. Data on HIV testing were missing for 18 survivors, among them 11 survivors who presented for care <72hours. Of the 250

survivors who presented within 72 hours and were eligible to initiate PEP, 83% (207 [183 female and 24 male]) were provided with baseline HIV testing. 32 of survivors who had presented for care <72 hours did not receive HIV counselling and testing thus missing opportunities for HIV PEP delivery and HIV prevention. Records of the HIV status of 10 survivors who recorded were missing. They were however continued on PEP indicating a HIV negative status. Of all survivors who tested at baseline, 5% (16) were HIV positive, of whom 13 had presented for care within 72 hours, and had been started on PEP and were thus discontinued. These data are lower than the national HIV prevalence of 7% which probably relates to the high number of children presenting as survivors.

Further examination of HIV positive survivors showed that of 116 adults presenting for care 88% (103) were female of whom 75% (78) received HIV testing at baseline. The female adult HIV prevalence in this study population at baseline was 12% (9) which are comparable to the national prevalence of 11% among adult women. There were no HIV positive adult males at baseline in this study population. Disaggregating HIV testing by age, 81% (119 [104 females and 15 males]) of all 147 children received HIV testing at baseline. Of the 118 children who presented within 72 hours and were eligible to initiate PEP, 85% (100) received HIV testing, 11% (13) did not and 5 had missing records. Two female children (both from Thika district) aged 17 and 6 years, and two male children from Malindi aged 18 were HIV positive at baseline. Both female children reported known assailants, while the male children reported not knowing their assailants.

8.3.4 Quality of HIV PEP delivery

PEP start doses were offered to all eligible survivors: 250 survivors were eligible for HIV PEP by virtue of presentation <72hours at the health facilities. Of these 207 were provided HIV testing and 194 were HIV -ve. Of these 162 were recorded as having continued PEP. None of the HIV +ve clients was continued on HIV PEP. However data shows that 180 clients were continued on PEP. The difference of 18 survivors was accounted for by:

- 5 survivors who had received no baseline testing and missing HIV test result variables and were continued on PEP,
- 3 survivors recorded as having presented >72hours but were continued on PEP,

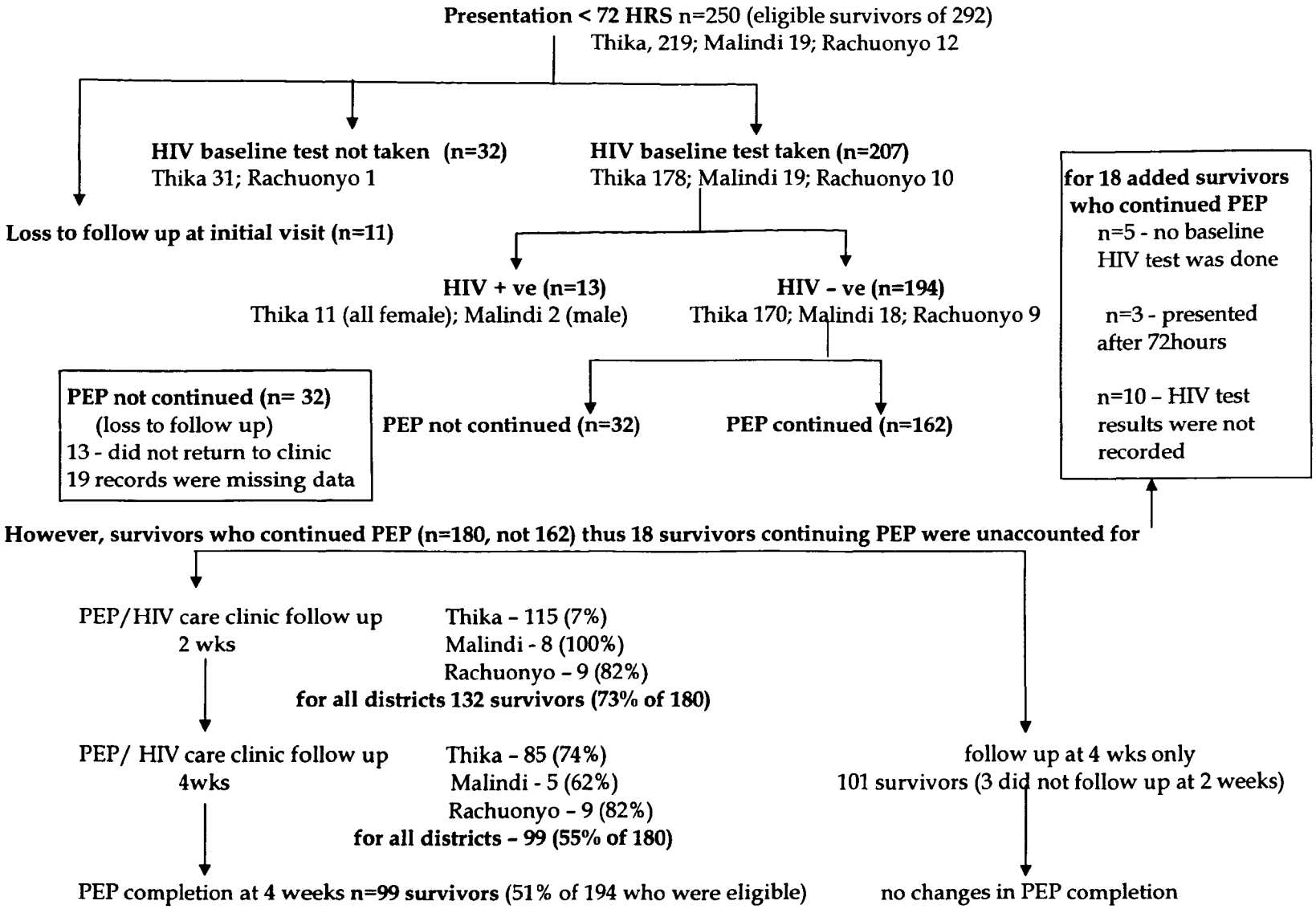
- 10 survivor records did not indicate whether or not HIV testing was undertaken at baseline and were continued on PEP

Two rationales were provided for this disparity in the numbers of eligible survivors in this study population who continued on PEP regardless of the eligibility criteria: a) that PEP was continued on clients whose HIV status was unknown, or b) poor recording at the HIV CCC meant that there were clients who received HIV testing but this was not recorded. Thus, it is possible that more than 232 survivors were provided with baseline HIV testing. Given that none of the HIV positive survivors identified at baseline were continued on PEP, in this analysis I chose to assume the latter rationale. That, survivors who were continued on PEP and did not have records of HIV baseline testing had been tested and were HIV negative, hence continuation. In describing HIV PEP follow up, I used the study population of all survivors that were continued on PEP (n=180).

Ninety-nine percent of the 250 survivors who presented within the 72 hour eligibility criteria for PEP were provided with the initial doses of PEP. 4% (11) were lost to follow-up prior to HIV testing at the initial visit or between the casualty and first clinic visits. 13% (32) clients did not undertake HIV testing at the baseline visit, a prerequisite for continued PEP medication, hence were discontinued. 6% (13) of the 207 who undertook HIV testing were HIV positive on initial testing. Among the 194 who tested HIV negative and were thus eligible to continue PEP, up to 32 (16%) did not continue PEP (13 did not attend the HIV care clinic appointment and 19 had missing data). Although only 162 clients were eligible to have PEP dispensed at the initial visit or casualty follow-up visit, 180 were provided PEP as described above. Among these, 73% (132) followed up at 2 weeks for their second PEP prescription and counselling and 55% (99) followed up at 4 weeks. Thus, of the eligible 194 clients (by virtue of HIV negative status after receiving baseline HIV testing), 51% (99) of survivors had all 28 days of PEP medication completed. Although PEP completion data were not collected, no more than the number who were given all of the medication could have completed the course and attendance at the 4 week visit is a surrogate for being more likely to have completed.

32% (67) survivors were retained and received 6 weeks HIV testing. 1 sero-conversion of a 7 year old female from Malindi was documented. There were no reports from both the survivor and the guardian of any additional exposure to HIV during the PEP medication period. This seroconversion could be a case of probable PEP failure or poor adherence to HIV medication.

Figure 8.3 Flow chart of the quality of HIV PEP delivery



8.4 Analysing acceptability of post rape care services among service providers

All service providers (front line staff and health managers) were asked, *"Are you aware of post rape care services in this institution?"* If they responded that they were aware, they were asked, *"Do you think other people within the health facility area aware of these services?"* Probing was done on the interviewee perceptions of these services and issues influencing access and delivery of services at both the health facility and the community.

8.4.1 Awareness of Post Rape Care services by health providers

All service providers interviewed were aware of post rape care services in the three health facilities. One health provider who had been in Malindi for 4 months heard about post rape care services 3 months later. This may reflect inadequate orientation about post rape care services at the health facility. One records officer from Thika was aware of these services, but did not know what they were, where they were situated or what they offered.

All health managers felt that other people within the health facilities were aware of the services as well. 3 front line service providers from Thika, and 2 from Malindi felt that not all people within the institution were aware of the services. 1 provider from Thika noted that staff within the key service delivery departments were aware, but that other staff such as in the wards were not aware. An example of this was provided where a 14year old girl was provided acute management at the casualty and started PEP, and required admission. During a ward round by a clinician on the third day, they discovered that the girl had missed two doses of PEP due to lack of knowledge by the nurses.

Lack of information amongst health facility staff was attributed to transfers and lack of on-going training for health providers. All service providers from Rachuonyo felt that there was awareness in the institution of PRC services.

Service providers had been informed of the services either through training or through booklets and posters provided by LVCT within the health facility. 2 health providers from Malindi had been trained by other health workers who had attended training. While most health providers felt that people within the health facility were aware of post rape services, all

interviewees noted the need for on-going and continuous education and sensitization amongst health facility staff. 4 respondents from Thika (including 1 manager), 3 respondents from Rachuonyo, 1 from Malindi felt that Liverpool VCT should step up awareness creation efforts in the hospital and amongst the communities. One front-line service provider from Malindi felt that continuous medical education programmes should be better instituted in the health facilities and regularised as these would provide a more reliable avenue for delivery of health information.

Awareness of services at community levels was reported as low. This information was not explicitly sought from the respondents. However, in all interviews, service providers (frontline staff and managers) felt that there was limited awareness or no awareness of post rape care services amongst the public served by the health facility. Increased awareness in the form of community education through public meetings, commonly referred to as baraza's was the most cited means of providing information. 1 service provider from Thika noted the need for Chiefs and other community opinion leaders to be trained and sensitized on issues related to sexual violence and on the need to present these cases to the health facility.

In Thika, the most oft cited method by 3 front line staff and 1 manager was closer collaboration between various service providers at the health facility to include the public health teams. It was suggested that post rape care services information should be tied into other HIV/AIDS campaigns that were on-going in the district. All respondents felt that community awareness strategies should include information on; the availability of services at the local health facility, what rape is, what should be done if rape happens including the need to present to the health facility immediately.

8.4.2 Health providers perceptions

All interviewees felt that post rape care services had filled an existing gap in their health services delivery. There was a sense of ownership of services from all managers in all the health facilities that was reflected in statements on plans for improving the services, plans for training, discussions of post rape care service challenges and issues at the District Management Health Team meetings. They were described in various ways

"extremely useful... and now we are going to expand them to our lower level service stations...something like the way primary health care is decentralised..." (female, manager, Rachuonyo)

"It was just recently when we talked about this issue of whether to use DCT or VCT services for counselling the victims at the DHMT...and the DASCO is following up..." (male, manager, Thika)

"...and now we can offer something useful for victims including preventing HIV and pregnancy. This was a very good idea and it has made us more competent... we are somewhere now, not where we were before...people who have been raped can now rely on the hospital to help them more..." (male, laboratory service provider, Malindi)

"This was a very good idea, and the services, very useful. It was a good vision for you to come up with this and put it in place as many people are benefiting. You know we also come from families and we see these things in our community. Now is to get people to use it (the service) especially in our area where HIV is high" (male, service provider, Rachuonyo)

Differences emerged between front-line service providers and managers in Thika. Five of nine front line service providers felt that there was no, or minimal involvement of other health facility staff in knowledge and delivery of services, while all managers felt that other facility staff were adequately involved and made aware of services. Service providers felt that much more could be done to improve the challenges in the service in contrast to managers who felt that services were well functional and coordinated.

One front line service provider from Malindi felt that these services should not be referred to as 'post rape care', as this created stigma.

Two health managers in Thika, one in Rachuonyo, one in Malindi and two front line service providers (from Thika) felt that the attitude of health providers was negative. It was described using terms such as *"hostile", "still unfriendly", "not supporting to the victims".*

Fourteen service providers and four managers from all facilities however felt that there had been a great improvement in health provider attitudes towards survivors.

8.4.3 Meso level (community) factors influences on uptake and delivery of services

While the numbers of clients presenting for post rape care were noted as increasing, all but one interviewee felt that there were many non-presenting survivors in the communities. Twenty one informants (from all sites) noted 'stigma' as a reason for lack of access to services and was often linked to the need for community education. Pressure from families on survivors was seen as a challenge to reporting and to compliance with treatment.

> *"stigma is still a challenge in our communities...makes it hard for people to come to the health facility..."* (female, manager, Malindi)
>
> *"fighting stigma and family pressure is very hard. I think what we need is very aggressive campaigns, like you people did for VCT, then people can start talking about rape...it is still a hidden subject... No matter how good the service many people will still not come"* (female, manager, Thika)
>
> *"family pressures are challenging, threatening at home reduces the chances of patients coming back for medication..."* (male, service provider, Rachuonyo)

Health providers as constituents of communities, and their own perceptions and interactions with stigma that is associated with sexual violence also emerged from the discussions. Descriptions of these experiences were mainly from Rachuonyo.

> *"people know that rape is happening, I know like 2 places where it has happened in the village, but people are not willing to report. Coming to the hospital is like going reporting and making it public, then the family will get stigmatised. I have even been to follow up with one family and they refused to bring the girl to hospital... even after discussing HIV with them... there is a lot of stigma in our community here"* (female, service provider, Rachuonyo)
>
> *"I keep it to myself if my daughter is raped or keep it to the family and not tell people lest my daughter will not be married in the future... they will be pointing fingers at her..."* (male, manager, Rachuonyo)

It was not clear from the transcript whether the interviewee was discussing what he would personally do in such a situation, or summarising his perception of community actions in situations of sexual violence and this was not explored by the interviewer.

Practices associated with rape were seen as a challenge to health facility presentation. Forced marriage of the survivor to the perpetrator did not encourage reporting.

8.4.4 Referral mechanisms

All interviewees were asked what post rape care services entail, what protocol for management of a rape survivor is used in the health facility with probing on information about all service delivery points (chapter 6.2-3). Service providers were also asked to detail the exact procedures undertaken in each of their departments.

All front line service providers were knowledgeable on the protocols and procedures for services delivered in their respective points. For instance, all clinical officers located at entry points (casualty and the HIV clinic) were clear on the procedures for examination and documentation and acute management including administration of prophylactic treatments. The protocols for management at each point were described as

> *"clear and concise – especially the wall charts..."*

Clinicians based at the PEP follow-up points and all rape trauma counsellors were knowledgeable on the protocols of management for services offered at other delivery points. Records officers were unaware of the different services delivered at different points. Laboratory staff from Malindi and Thika were not knowledgeable on protocols for services offered in other points. As one service provider from Malindi noted,

> *"I am not very clear on the exact procedures of what happens in the other referral points, but can just say generally what is done there".*

All laboratory staff felt that HIV testing in the context of sexual violence should be delivered by trauma counsellors rather than send clients to the laboratory.

Six of 11 managers interviewed had an understanding of the requirements for management of survivors of sexual violence, but were not especially knowledgeable on the specific protocols for services delivery at the different service delivery points.

All Health Records Officers interviewed felt that the post rape care programme was not well integrated into the health facilities and the health care system. They noted the need for health

records to be captured in the HMIS and that post rape care data was not. They also expressed limited understanding of the protocols with exception of the Malindi Records Officer who was aware of the referral mechanism for survivors.

All clinical officers and nursing officers in charge at all sites that were interviewed were clear on the referral system and expected client flow (figure 6.1) through which survivors access all of the services. All service providers from Rachuonyo, two from Thika and five from Malindi were also clear on the referral. Those service providers that were not clear on the referral system knew the requisite service delivery points.

Challenges in the internal referral system were attributed to the nature of the system that has too many referral points for services delivery. It was described as 'complicated', "unclear" and *"mixed"*

> *"it is frustrating even for us and I think humiliating and emotionally disturbing for the patient"*

Further challenges in service delivery were expressed. 2 medical officers, 2 clinicians and 4 counsellors noted challenges in adherence to medication by survivors, challenges in disclosure of HIV status and sexual violence among survivors. Part recommendations included strengthening referral and follow up systems.

Coordination of various services for delivery of post rape care was considered challenging, but possible by all managers. Challenges were seen in the nature of diverse services and skill that required to be availed for the survivor. Two medical officers and two DASCOs mentioned the varied nature of management of services required by the centre. The vertical delivery and reporting nature of HIV services was said to be challenging to integration of post rape care services.

> *"the challenge of integration is that HIV is run directly from NASCOP. It becomes difficult to integrate with other services. This is not only for PRC services, but others such as paediatric illnesses especially in managing infant and childhood illnesses such as offered through immunisation programmes..."* (female, medical officer)

External referrals were unclear in all sites. They appeared to be most developed, though not institutionalised in Malindi.

8.4.5 On-going training

All interviewees felt the need for additional training for themselves and for other staff in the health facility. Primarily, the limited numbers of rape-trauma counsellors were cited by all counsellors and clinicians interviewed. The need for training all service providers in the district health facilities in delivery of post rape care services was noted by 8 service providers from all sites. This was often in reference to examination, documentation and PEP administration.

The majority of front line service providers from all three health facilities expressed increased knowledge and ability to provide services to survivors. All clinicians in casualty with the exception of a nurse from Rachuonyo, and all laboratory personnel except 1 from Malindi indicated the training as having been very useful in building skill, knowledge and confidence. One male medical officer noted,

> *"...am certainly more confident filling in the P3 forms. Nothing is missed and court presentations are a lot easier and more concise. I think this kind of thing should be taught in medical school, including the counselling and attitude change stuff... it's very good for stigma reduction as well... particularly as most of the patients are women..."*

The questionnaire did not explicitly ask a question of the gender training. However, 13 service providers mentioned the importance of this part of the training and mainly in reference to change of attitudes. It was described as *'important, 'critical', very useful for providers...*, since, *sometimes they (health providers) just don't know about gender...'*. Two providers, one female nurse and one male clinician felt that it did not add much value to the training.

Despite acknowledgement of having skills and knowledge, one counsellor and one nurse reported that they felt that there were few staff who were comfortable in providing services to the survivors and thus most clinicians were more comfortable with sending patients to

counsellors. This was attributed to limited counselling skills among service providers. One female service provider in Thika noted this as the reason;

> *"...hostility and fear of attending to patients. Even those doctors do not know how to handle the survivor. They just want to treat them and then pass them to the counsellor... those at casualty and the patient support centre, they need some training in basic counselling skills".*

All counsellors felt that the value based training was useful and should be extended to clinicians. In addition, counsellors felt that the course was *'experiential', very good for skill building as a counsellor', 'acknowledges difficult issues'*. It was seen as critical not only for trauma counsellors but for a range of other counsellors, by one counsellor from Malindi, *"... it provides such awareness of oneself... all counsellors should really do this".*

Laboratory personnel in all sites felt that training on specimen collection, analysis, documentation, storage was insufficient and would require to be further expanded within the 3-day training for clinicians or issued as a separate training.

On-going training for health providers was seen as essential by all interviewees. Staff transience necessitates on-going training. Systems to ensure that those who received training then provided information to other staff are required. It was noted that when few staff receive training, it was often not passed on to other staff with the exception of Rachuonyo. In Rachuonyo, such a system exists, where continuous medical education is undertaken through one-hour trainings each week. Staff felt that this system should continue to be supported.

In Malindi police training was regarded as key to the implementation of post rape care

> Interviewer: *"What about the police? Are they of any support concerning rape survivors?"*
>
> Respondent: *"Yeah, we have seen a change since the workshop which was done, there's a change, a great change, because any time they bring cases immediately. I haven't gone to the police but I hear there's a desk there now for females... they call it gender... the workshop was able to change those who attended it and anytime they see it's some rape case or traumatized, I can see there's a change and even the way they are referring the survivors, I can see it really helped. There should be more training for police. It is really necessary".*

All managers and interviewees, especially from Thika expressed as a pressing need additional personnel and space to deliver post rape care services. In Malindi and Rachuonyo, the need

for additional personnel was noted. In particular, on-going training at casualty was noted as required as there was a high turnover of staff.

8.5 Discussions: Implications of these findings on uptake and delivery of post rape care services

8.5.1 The demand for post rape care services

Health providers not only expressed acceptability of services but a clear need and that the implementation of post rape care had filled in an existing gap (7.4.2). Medication given for post rape care, located in the bio-medical and disease related level of the VHA framework aims to mitigate negative health outcomes (1.5; 2.5). Majority (82%; 73%) of eligible survivors received emergency contraception and STI prophylaxis respectively (8.3.2). The symptoms or efficacy of these bio-medical interventions were not determined as they were outside my study scope (1.6), but are assumed to have been efficacious based on literature (2.5). I am unaware of any pregnancies that may have occurred, among study participants as a result of EC failure. Symptoms and side effects of the trauma and/or HIV PEP medication were not described. These data demonstrate that delivering these range of clinical services in disparate points of service delivery is possible, but requires strengthening of the client flow mechanisms (discussed further in section 8.5.7), aimed at 100% delivery of the standard of care for all presenting survivors.

8.5.2 Social factors influence uptake of services

The majority of the presenting survivors were children. The extent to which this reflects the trend of sexual violence (rape is more common among children), or reflects challenges of reporting by adults due to stigma, self-blame and shame (2.6; 3.6; 5.8) is unclear. Drawing on the WHO multi-country study[75], there are many women who do not present for care for fear of violence, of stigma or a lack of awareness of what to do (5.6). In addition, findings in chapter 5 demonstrate, the varied understandings of sexual violence (5.2-3), the unclear boundaries between consent, coercion and force (5.3), the implicit sanctioning of sexual violence by women and men (5.8.1), stigma associated with male and female rape (5.8.1,4) may also negatively influence adult uptake of services.

All 40 (14%) of survivors who presented >72 hours for care, reported knowing their assailants, suggesting that this may impact negatively on presentation. The blurred boundaries between coercive, forced and consensual sex (5.3.4-6), the varied conceptualisations of sexual violence (2.4.2; 5.2), the gendered expectations of the primacy of male sexual desire and the expectations of women to satisfy these (5.5.3), which are likely to apply in the context where perpetrators are known may negatively impact on uptake of services. A person who perceives themselves to have 'consented' may be unsure whether they were sexually violated and unsure of reporting and may not take up services (5.3.6). This challenge may also be a reflection of the varied definitions of sexual violence (5.2). The confusion emergent and sense of shame means that survivors are unlikely to present for care and support, or to prevent future occurrences.

8.5.3 Children specific services

Children were more likely to be violated by people known to them, supporting suggestions that younger age is associated with increased vulnerability to sexual violence (2.6) from within their community. Drawing on the literature, the high numbers of children may espouse a perceived threat to society's moral order (2.4.2) and thus a felt need to address this through presenting for care. It is also unclear whether the high numbers of children presenting were a reflection of: the legitimacy of the perception by radical feminisms that sees the rape of girl children by family members as an integral process of sexualization (2.4.1); the varied conceptualisations of sexual violence and by extension acceptable sexual play for adults and children (2.4.2); emerging social power structures that dictate and sanction male sexual behaviour (2.4.3); the potential social vacuum existing in the context of a problematic concept of 'African culture' (5.8), or a combination of some or all of the above. Children's (girls and boys) vulnerability to sexual violence has been associated with their limited social power. Given these factors, it is probable that sexual violence against children is also implicitly sanctioned by society as a sexualisation process, based on children's placement in the social hierarchy.

These data has implications for the strategies adopted for delivery of post rape care services. For instance, the training for health workers did not have a specific section aimed at services delivery and addressing the special needs of children in physical examination and medication

supervision at the beginning of the study. However, in November 2004, with the high number of children presenting, we developed weight band based guidelines for appropriate paediatric dosing of PEP medications[317], and incorporated child counselling training sessions into the counsellor training manual in February 2005. HIV testing protocols for minors remained challenging throughout the study as there were no national guidelines within Kenya for paediatric HIV counselling and testing. The meanings of sexual violence against children remain under-explored in Kenya, and require further understanding in order to effectively inform health and justice system responses for children.

8.5.4 Social perceptions influences on HIV PEP uptake

The blurred boundaries between coercive, forced and consensual sex (5.3.4; 5.3.5) pose two specific challenges for HIV prevention in the context of high HIV and STI prevalence rates and on-going exposures associated with women's social vulnerability. *First,* there are potentially increased risks for HIV infection in many non-presenting survivors, missing opportunities to impact on preventing future occurrences through counselling. *Secondly,* indication of PEP in survivors for whom repeat exposures are likely undermines the goal of PEP delivery and the opportunity for providing on-going HIV risk reduction counselling is lost. Thus, the question of whether PEP should be provided for chronic exposures still remains unanswered even at the time of writing this thesis. It also raises questions regarding the extent to which the health sector can continue to effectively prevent HIV infection without engaging the socially located factors that influence vulnerability to HIV and to sexual violence. This challenge also has implications for PEP resource allocation and policy formulation that are briefly discussed in chapter 9.

Uptake of HIV testing in order to access PEP potentially places HIV positive female survivors at increased risk of violence[318] and stigma. This may partly explain why 15% of survivors may have declined HIV testing, even when 32 had presented for care within 72 hours and were thus eligible for an opportunity for HIV prevention through PEP (8.3.3). This is particularly relevant in a context where the HIV prevalence among adult women was 12% in this study population which is comparable to the national female prevalence of 11%.

8.5.5 Other contextual HIV risk among survivors

2 adolescents and 9 adult women were HIV positive, and 3 women were pregnant (a surrogate indicator for unprotected sex) at baseline (7.3.3). These results demonstrate other contextual HIV risk among adult and adolescent survivors prior and possibly post PEP medication. HIV risk behaviour were not described in this study population, with PEP delivery focused on the one sexual violence occurrence. This means that opportunities for leveraging the moment of presentation by survivors to leverage on-gong HIV risk reduction counselling, while acknowledging HIV risk behaviour in the context of blurred boundaries between forced and consensual sex were not utilised. Understanding contextual HIV risk among survivors, and developing a module to effectively address this in the context of trauma and HIV testing remains an area for further research. Lessons learnt from the more developed VCT services in risk reduction counselling could be evaluated and built upon.

8.5.6 PEP adherence strategies and social influences

Of 67 survivors who were tested for HIV at 6 weeks, there was one documented sero-conversion of a 7 year old girl. The probable causes for sero-conversion include PEP failure or incomplete adherence, as there were no reported additional exposures in this survivor during the PEP medication period. There has been increasing literature on possible PEP failures during the period of this study (2.5[96,111]). Adherence was not measured in this study population, but was suggested to be poor from interviews with clinicians and counsellors (8.4.4). Disclosure of sexual violence and HIV status was also described as problematic and was given as a reason for poor adherence. Comparable data on the notion of 'family pressure' being a challenge to uptake of care, retention of survivors (8.4.3) further highlights the need for consideration of social influences in delivery of PEP medication.

Prescription of PEP raises the possibility of further stigmatisation of women. The fear of being at risk of having been infected may cause fears of transmitting HIV to partners and anxiety over recommendations for abstinence or protected sex during PEP medication and for at least three months after exposure (2.5). This may be problematic for many women who have limited bargaining power to negotiate safe sex (5.3.3; 5.3.4; 5.8) and who may fear the repercussions of disclosure of sexual violence.

8.5.7 Counselling and HIV PEP outcomes among survivors

Health care systems and structures (that speak to the meso/macro levels) need to include both counselling and clinical services. This need has been highlighted before in literature (2.8.4)[319]. This study provides information that points towards links between counselling and clinical outcomes of PEP completion (8.3.4). I acknowledge the challenges to this data including the limited sample size and the inherent bias in utilising presenting survivors only (given the lack of literature on possible profiles of survivors who present). However, these data provide a basis on which further studies to evaluate the effects of the counselling protocol developed could be undertaken. What is clear is the need to integrate counselling interventions and clinical care that are often disparate in the health sector for improved clinical outcomes.

In this study, we developed a counselling intervention that was demanding (5 sessions of which we expected that survivors would attend a minimum of 3). This meant an increased cost on the survivor in terms of transport and time requirements, and on the health facility in terms of human resource. This may explain the low follow up rates (40%) achieved for at least 3 counselling sessions. In addition, the data demonstrated an association between PEP completion and first counselling session only. This suggests the need for more targeted and briefer counselling intervention. It would need to take into consideration the social factors of stigma, shame, blame that the survivor contends with during and post medication.

This study focused on psychosocial support of survivors with respect to immediate and short-term health outcomes. There are no interventions or data on the on-going psychological health of the survivors and the impact of HIV testing, particularly for survivors who are HIV positive at baseline and were unaware of their status.

8.5.8 Integration of services and follow up systems

The loss of clients within the client flow algorithm is high. In addition, service providers in all health facilities felt the need to make the algorithm simpler (7.4.4). Suggestions offered on improving the algorithm were faced with various challenges. Delivery of HIV testing in VCT was made problematic by the nature of VCT (in accordance to the national guidelines) where

written results are not provided to clients, a necessity in the context of post rape care. Delivery of counselling in the casualty could be further explored as an opportunity to reduce client movement within the referral pathway. Challenges herein include, lack of counselling personnel at casualty and the fact that casualty is not the only point of presentation in each health facility, as demonstrated by this study (table 8.2). These data however, provide a first model for integrating post rape care services into health services in resource limited settings. There exist opportunities for each setting/health facility to explore ideas through which this basic algorithm can be adjusted to fit diverse needs while ensuring that all the requisite services are provided.

A key issue emerging for all records officers was the lack of harmonization of the post rape care programme with the District Health Management System. The caveat however was in that the HMIS was directed from the centre and run vertically. Records offices were also challenged in human and technical resources and expressed this more than other providers. These findings demonstrated the need for engagement with policy at national level to develop standards that could then be integrated into the national HMIS. The policy engagement process is documented in chapter 9.

PEP uptake and completion was poor (51%) in this study population. 49% of survivors who continued HIV PEP were lost to follow up. This suggests that there may be meso/macro level influences, associated with household and community level factors that were not determined in this study that negatively impact on the ability of the survivor to present for return visits to the health facility. What remains clear is that active follow up systems aimed at retaining survivors for counselling, PEP medication and for post medication HIV testing are required. In addition, the factors associated with stigma, violence, the intersection of psychological and physiological symptoms of both sexual violence and HIV PEP need to be explored further. These could provide additional knowledge on how best to address challenges of retention and follow up.

8.5.9 Targeted and value based health provider training

The training for health providers was considered important and relevant for service delivery (8.4.5). Skill and knowledge delivered during that training offered to both clinicians and to counsellors provided a basis on which to provide services (8.4.5). The job aids provided as part of the training including the wall charts appeared to have been of value to the providers. During the process of engagement with policy, there was attention to development of simplified protocols for clinicians and for counsellors. Training was focused mainly on service providers from service delivery points that were outlined in the algorithm. The challenge of attrition in the system remains common. Knowledge transfer to new providers by trained providers was not always undertaken. Further, at the beginning of the study we had not envisioned the need to orient all health providers (7.3.3) - a strategy that we adopted during the intervention, from the experience of the 14year old in Malindi (8.4). The need for training to target auxiliary and support staff in non-service delivery points was reflected by most respondents. The high loses of survivors within the client flow system may also be a reflection of the lack of clarity about referral mechanisms among service providers (7.4.4). Thus, targeted training is critical to the acceptability of post rape care services amongst health providers and therefore for delivery of services.

Stigma was an issue raised by majority of health providers (8.4.3). In determining the perceptions of service providers (5.7.2) at the start of the study, stigma was not significantly highlighted by service providers as a reason for poor presentation. During training (7.3), however, it emerged from service providers. Therefore we explored provider participation in being part of the performative community process in responding to sexual violence and this may have increased recognition of stigma as an issue for the health providers, for survivors and thus for delivery of services. Value based training that focused on gender and service provider attitudes were considered important to services delivery (8.4.5). The extent of the impact of this value based training is unclear, but this data provides a platform from which inquiry into the most appropriate methods to engage service provider commitment in engendering the health sector is possible. During the policy engagement process, we engaged in supporting the development of a national curriculum for training health providers (8.3.3).

8.6 Reflexivity: successes, issues and challenges

These results presented for me a sense of satisfaction that the strategy implemented provided services for survivors. This section briefly outlines my reflections of these results, the utility of the study approaches and tensions for me.

Utilising the VHA framework allowed me to explore the interrelations between micro, meso and macro level influences. I was able to continuously investigate the relationships between these three levels and the ways in which they intersect to affect service uptake and service delivery. I was able to draw on findings that described social constructions of sexual violence (meso level), to investigate and demonstrate links with service delivery challenges (macro-level) and explore how these intersect with bio-medical and clinical outcomes. For instance, contextual HIV risk guided by the understanding of blurred boundaries between force, consent and coercion (meso-level) increases the complexity of counselling for HIV testing and PEP adherence (macro-level), and impacts on PEP outcomes (micro/bio-medical level). Thus, the quality of counselling and HIV PEP delivery is compromised. I was able to draw on the ecological model to examine how gender mediates the uptake and delivery of a standard of care to impact differently on women and men. It was the flexibility of these two instruments that allowed me to explore and draw links between socially located issues that influence sexual violence (chapter 5), utilize these to develop an intervention for response (chapter 7), and assess the implications of the interventions for the health sector responses (chapter 8). .

In chapters 5 and 6 service providers alluded to gender influences in delivery of the standard of care. These intersections have implications for services delivery. For instance, in Kenya, the P3 form can only be filled by a medical doctor who is also required to be the examining physician. Where there are challenges in examining survivors, as was demonstrated (6.6.3) there emerge the potential for poor documentation and insufficient assessment and examination. There are also implications for secondary trauma to the survivor and subsequent compliance or drop-out of treatment.

Addressing sexual violence requires primary prevention interventions. While health sector responses are necessary, there is need for action within the entire prevention, care and rehabilitation continuum for sexual violence. The need for a community based awareness

campaign and training was noted consistently by service providers (7.4.1). This still remains a gap in this thesis, and a research opportunity to explore the potential for an effective information and behaviour change communication strategy. In addition, district level on-going campaigns should be actively targeted as points of dissemination for information on post rape care services.

Health sector resource and capacity challenges impact negatively on the ability to undertake well documented research efforts that are reflective of the lived situation. However, methodologically sound research requires documentation. The tensions between these two issues remained real challenges for me during the study. On the one hand, there was a need to develop systems that can be integrated into current health care services that are fraught with poor human, financial and technical resource capacities. On the other hand is the need to collect good quality data that can be effectively utilised for research and for programming. The extent to which designated research staff may/may not be utilised without compromising the potential for effective integration remained challenging for me through the study.

Chapter 9 Strengthening health sector response to sexual violence in Kenya: informing policy and service delivery practice

9.1 Introduction

In this chapter I discuss the requirements for post rape care services in Kenya, in response to the question asked in this thesis. I also outline what was achieved through this thesis and gaps that remain. I focus on my engagement with the policy level, and the implications for post rape care services in Kenya. During the time that I continued to analyse data and write up this study, the post rape care programme continued to evolve. A post-rape care programme was initiated at LVCT a coordinator was employed as services were expanded to cover additional facilities. When I began the study, I envisioned that an understanding of the requirements at the practice level (health facility) alone would provide me with information to sufficiently inform a response to the policy requirements. However, during the journey of the thesis I increasingly realised the importance of policy engagement, and that there were system related issues that were requirements at policy level to necessitate translation to local level. In this chapter, I provide an outline of the current status of the post-rape care programme, to demonstrate:

- the effects of this study on the health sector in Kenya
- that there is a demand and thus need to expand the post rape care service
- that the post rape care service delivery model developed in this study is applicable to other settings in Kenya
- the intervention documented in this thesis as a practical approach to delivering post rape care services in resource limited settings

Section 9.2 outlines the policy engagement process presenting key activities and their outcomes. I frame the intervention process used in this study as a five stage process that I suggest can be utilised to develop post rape care services in other settings both in Kenya and in other resource limited settings (9.4). I reflexively explore my positionality understanding that this influenced my interaction with policy formulation (9.3.1). I conclude (9.4) by highlighting contributions made and issues emerging regarding national programming, research and policy that have emerged as a result of this study.

9.2 The policy engagement process

9.2.1 The Ministry of Health institutionalized post rape care services

The decisions made by the DRH and stakeholders through the Joint Inter-Agency Coordination Committee (3.8.3) were documented as reports and minutes of meetings that are available at request from the DRH. In this subsection, I document the progress made at policy level in so far as it has implications for: 1) service delivery at health care levels, 2) the research question in this thesis that attempts to draw on the experience of local service delivery development to point out policy implications. Table 9.1 outlines the key activities undertaken in the policy influence process, the timelines and outcomes of each activity.

Table 9.1 The policy engagement process

Time frame	Activity	Comment on the outcomes of the activity
July 2004	Discussions with Programme Manager of the Gender & Reproductive Health Rights Working Group at the DRH	A meeting with the Head of the DRH on the findings of the study and potential implications for policy development and formulation. I focused on health provider need for national guidance, on the mandates of the DRH and potential for LVCT support to the DRH
August 2004	Stakeholders meeting of partners interested in delivery of post-rape care services convened by the DRH.	i) I made a presentation of findings outlining issues, challenges and opportunities ii) Post rape care committee* formed with a range of representation from civil society and government partners.
August 2004	Terms of Reference of post rape care committee drawn	3 sub-committees developed; i) develop national guidelines, ii) develop training curricular, iii) develop communication strategy
December 2004	First draft of national guidelines developed and shared with stakeholders for feedback	i) Range of comments received and the need for a policy guidance framework on post rape care identified. ii) Discussions with the NASCOP on PEP policy guidance were initiated. iii) The need for a documentation and examination form that could be legally utilised identified
February - April 2005	DRH approaches partners. Population Council provides support for a background paper for a policy framework. I was involved (with 2 consultants) in this paper	i) Final draft of the national guidelines is produced ii) Sexual violence is included as an issue in the Reproductive Health Policy iii) Post rape care indicators and outputs are included in DRH business plan for 2006/7
February - September 2005	The PRC1 form** for documentation and examination developed.	i) The form is piloted 5 health facilities ii) A meeting for health managers in the 5 health facilities is held in June 2005 and feedback provided for review of the PRC1.
September 2005	LVCT produces a policy briefing on development of post rape care services. National guidelines launched	Briefing is disseminated at the same time as the National guidelines on the medical management of sexual violence are launched by the DRH. There is much media interest in both documents and a media briefing is developed by the DRH. These documents are highlighted in the Kenyan media on September 20th 2005

Time frame	Activity	Comment on the outcomes of the activity
September 2005	Sexual violence raised as an issue at the JAPR (3.7.3)	i) Survivors of sexual violence now identified as a vulnerable group in the Kenya National HIV/AIDS Strategic Plan (KNASPII) ii) The M & E framework of the KNASPII captures post rape care indicators***
September 2005	Post rape care is discussed as an issue in the DRH - ICC and I make a presentation on the findings to the ICC	i) DRH assigns resources for emergency contraception with support of the UNFPA ii) Decision made to engage other service providers including NASCOP iii) A recommendation for a budget line for DRH financing for year 2006/7 for post rape care is made. This is however made problematic by lack of information on costs for service delivery
October 2005 - May 2006	Training manual for clinicians and other health providers developed	i) Document based on the LVCT and the Nairobi Women's Hospital training manual ii) A series of 3 workshops undertaken to develop the national training document iii) Manual published and disseminated as national guidelines for training
August 2005 - November 2006	Trauma counselling protocols and training programme developed	i) 2 psychologists from the National referral hospital and professional counsellor identified ii) A wide range of stakeholders involved in the 15 month process
June 2006	NASCOP engagement with the DRH is enhanced and post rape care services are part of the range of discussions	i) NASCOP assigns resources for PEP as part of ART treatment ii) NASCOP ART training covers PEP delivery and administration
September 2007	The Sexual Offences Act is enacted in Kenya	i) A sexual offences act implementation taskforce established ii) LVCT is affiliated to this taskforce to facilitate the gains made in the health sector. (the DRH is a key member of the taskforce)
August 2006 - May 2007	LVCT, DRH and the Health Policy Initiative mobilise resources and undertake a costing study****	The study is expected to: i) Provide new knowledge on costs for scaling up post rape care services in resource limited settings, given that there is currently no relevant cost data in literature (2.3.3) ii) Facilitate advocacy for government and partner financing to achieve the proposed scale-up plans iii) Facilitate the replication of post rape care services in other resource limited settings
July - October 2007	LVCT supporting DRH in engaging with the sexual offences act taskforce	i) it is expected that the PRC1 will be gazetted making it a legally binding document

Notes:

*The objectives of the post rape care committee were:

1. To develop national guidelines for the medical management of rape/sexual violence that would provide guidance and act as the reference for service delivery
2. To develop and institutionalise requisite protocols and tools to support the use of these guidelines and support the development of a documentation framework
3. To develop training curriculum, materials and guidelines for health providers. Training was noted as integral to the scaling up of the service
4. To develop requisite policy level inter-sectoral linkages to support the planning, coordination and delivery mechanisms for the different services required.

** The PRC1 form was developed for medical and legal documentation purposes. The committee borrowed from existing international forms used for forensic examination and documentation (such as in South Africa, in Britain) and adapted one that was relevant for Kenya, informed by the results of this study.

*** In the Monitoring and Evaluation Framework for the KNASP II in Kenya, HIV PEP and Post Rape Care have been captured as part of the National Indicators (# 47 - 51).

- # 47 - Number of health providers trained on PEP
- # 48 - Number of health facilities with PEP operational centres
- # 49 - % of police officer sensitised on PEP for victims of sexual violence
- # 50 - % of Anti-Retroviral Therapy Sites with PEP and Post Rape Care centres
- # 51 - % of health workers trained on PEP with Post Rape Care services

This in effect means that Government now has the mandate to report achievements on these indicators through the Joint Review Mechanism (3.8.3) and therefore requires to make resource commitments towards sexual violence.

****In August 2006, I approached the DfID, through the HAPAC III (3.10) for funding to undertake a costing study that would provide projections for scaling up of services. At the time of submission of this thesis (September 2007), the study consultants (Health Economists from the University of Nairobi), with technical support by Wasunna Owino (PhD, Health Economics, currently working with the Health Policy Initiative [a Kenyan NGO]), Dr. Kibaru

(the Head of DRH) and myself are preparing a briefing document for presentation to Parliament. This study will provide the first data on the costs of post rape care services, as there is no literature in this area (2.3.3). Data on cost effectiveness studies remains unavailable.

9.2.2 Contributions to the WHO policy on sexual violence

Gender advocates within the WHO have increasingly utilised the strategic framing approach to influence the health policy agenda with regard to sexual violence and particularly with HIV/AIDS interventions (2.4.3). In 2005, I was invited selected as a Technical Advisor to two WHO technical committees for the development of international standards.

- The **WHO Technical Committee for the development of international guidelines for HIV PEP for occupational and non-occupational exposures in September 2005.** I utilised this opportunity as a learning experience (2.2.2), and also shared our preliminary data and experience from this study to contribute towards the development of international policy.
- The **WHO Technical Committee on developing guidelines for HIV Counselling and Testing in the context of Gender Based Violence in January 2006.** Caroline Ajema, my research assistant represented me at this meeting.

9.3 Contributions to Kenya national programming, policy and research

9.3.1 National curricular for service provider training

This thesis contributed to the development of two national training curricula for health providers in clinical and psychological care. There is now need to integrate post rape care training into other curricular that cover relevant issues. For instance, the ART training curricular in Kenya should include PEP and emergency contraception and the client flow algorithm in order for clinicians to be aware. The training needs of a broad spectrum of service providers require evaluation and support. While the Provincial Reproductive Health Teams have to date been trained, Provincial and District ART teams, and laboratory personnel should be trained (3.8.2). This integration requires policy level commitment and support and will strengthen horizontal programming and scaling up of services.

9.3.2 The foundation for an evidence chain

This research contributed to the development of a clearly defined tool for clinical evaluation and legal documentation (PRC1) providing a basis for the development of a chain of custody of evidence in Kenya. While the PRC1 form provides for forensic examination and documentation, there have emerged challenges in its utilization and value as a tool to link health care to justice and thus prevention. This is primarily due to the lack of a functional system between specimen collection and analysis points within the health sector and the justice system who are the custodians of evidence. The causes alluded to as reasons for this gap include: lack of clear protocols for collection, preservation and analysis of specimen and evidence collected within health facilities, lack of systems for the management and utilization of results from the limited specimen that get analysed. Thus, further research is needed in Kenya to inform the development of a chain of custody of evidence.

9.3.3 Purchase and supply of post rape care kits

Debates that impact on the evidence chain relate to post rape care kits. In 2006, there were debates about whether post rape care kits should be assembled at the district health facility, through the Central Sterilizing and Distribution systems, or whether kits prepared and procured commercially should be availed. Concerns regarding commercial kits include: costs of purchasing the kits that had been seen as too high and unsustainable given the financial constraints facing the MOH logistics for distribution and supply of kits. This context of strained systems may increase ineffectiveness and the influences of commercial kits on health services providers who may not provide services to clients in situations of stock-outs. Rationale for adoption of commercial post rape care kits: the cost of treatment of patients remains pretty much the same to the Government, only that it will be spread across different departments. It is argued that opportunity and time costs may actually translate into higher costs for assembling local kits. Kits could potentially improve services delivery, reduce client losses during referrals and raise the profile and visibility of sexual violence management within health care service providers, which may improve the quality of services provided. To date no policy decision has been made.

9.3.4 Policy guidance on integration of counselling and clinical care

This study provides evidence for immediate action to collapse the fragmentation of services delivered in the health sector. This includes the disparate functioning of, a) psychological and clinical services and, b) vertical and integrated approaches. The results of this study on the association between counselling and PEP medication completion demonstrate that integration of traditionally disparate services is both necessary and possible. This acts as an imperative for national level integration and policy guidance on health facility integration. These findings provide an opportunity to explore the requirements for delivery of integrated HIV/AIDS services in the health sector, as well as the development of multi-sectoral collaboration to strengthen links between the health sector, prevention and rehabilitation services and the criminal justice system. Research to develop a module for policy level collaboration is necessary.

9.3.5 PEP delivery

Evidence of fuzzy boundaries between consensual, coerced and forced sex presents specific challenges for PEP uptake and delivery in health care settings that were not conceptualised during the study design nor the intervention period. Should PEP be indicated for presenting survivors in contexts where chronic exposures are likely? Given the low infectivity of HIV, should PEP be provided for all survivors or should there be a stratification criteria for those with highest risk exposures? And if so how would this stratification be achieved in a context of high HIV prevalence, where the perpetrator who is the source, would be unreachable with the immediacy required for PEP medication? These questions still remain unanswered. These considerations resulted in a decision by the DRH and NASCOP to offer PEP routinely for all presenting survivors as part of the national guidelines.

The debate on whether to use a 2 or 3 drug PEP regimen remains (2.5.2). There are still no data to describe the risk of adverse symptoms and events or non-adherence and compliance associated with either regimen. Thus, in selecting PEP medication guidelines the DRH and NASCOP made considerations for cost and adherence. A third drug was identified having the potential to increase the cost of PEP considerably as well as the complexity of medication adherence and side effects (2.5.2). As more data emerges on HIV PEP delivery for sexual

violence in high prevalence settings policy considerations for these issues may require revision.

9.3.6 Programme evaluation needs

Indicators used to assess the success of the interventions were designed specifically for the purposes of this research (4.11). Thus, they could not be extended to use in routine service delivery. This was demonstrated by the large numbers of incomplete data sets received even in the context of on-going supervision. There was no intentional design of long-term evaluation of services. Further, one of the key challenges was the lack of clear links to the health information management systems at health facility level as highlighted by health provider (7.4.4). Thus, there remains no clear system to judge the cost effectiveness of on-going programmes and assess the utility of the innovative approaches we utilised or increase the effectiveness of programme management and administration. Developing an evaluation model for the post rape care programme will be required by the Ministry of Health, particularly given the scale-up plans. This may provide an on-going foundation for quality improvement and may also contribute to new knowledge on evaluation of programmes that cut across vertical and horizontal approaches, and integrate HIV/AIDS and Reproductive Health concerns.

9.4 A model for developing post rape care services in resource limited settings

A model based on 5-stage framework suggested below provides a process through which post rape care services can be developed and delivered. It is based on the approach documented in this thesis as a practical tool for post rape care delivery that LVCT continued to utilise to expand the post rape care programme. Stage 1 is reflected as objective 1 of this thesis where a baseline analysis was carried out (chapter 5 and 6), stages 2, 3, and 4 are reflected as objective 2 of this thesis, the intervention (chapter 7), and stage 5 is reflected in both objectives 2, on-going consultations (chapter 7), and objective 3, documentation and assessment of the success of the intervention (chapter 8). I provided titles for each stage. The following first outlines what was done within that stage in this study, and then it's importance within the context of developing post rape care services in different contexts, thus highlighting its utility.

Stage 1: Baseline analysis

In this study: It included the adoption of a gender lens to recognise the micro, meso and macro level influences of sexual violence. A literature review identified the micro level influences, while primary data collection complemented identification of meso and macro levels (chapter 5).

The utility of a baseline analysis in developing post rape care services: It facilitates an understanding of the a) bio-medical needs, b) the local constructions of sexual violence and their interactions with intended interventions, and c) the structural and infrastructural capacities and needs for uptake and service delivery. A gender lens recognizes the different experiences of women, men, girls and boys. The VHA framework and ecological model provide appropriate tools for such an analysis.

Stage 2: Health manager's engagement

In this study: We held consultations with the DHMTs before initiating the intervention at practice level. At the policy level we held consultations with Programme Managers at the Division of reproductive health continuously presenting and sharing lessons learnt.

The utility of health manager's engagement in developing post rape care services: Health management teams and policy level managers require involvement in planning for, developing and implementing services delivery mechanisms as they are the custodians of these processes. Participation and empowerment for the health facility and health ministry personnel, structures and systems as goals of interventions, facilitate acceptability of services.

Stage 3: Standard setting

In this study: At practice level, I developed a standard of care, with protocols to facilitate delivery including, an algorithm (figure 7.2), protocols for examination and documentation (annex 10) and protocols for counselling (table 7.1; attachment 2) that were available at service delivery points. These were identified as critical in service delivery (8.4.5).

At policy level, the DRH utilised its mandate for planning, regulation and coordination of services to constitute a post rape care committee that developed national guidelines and training materials that set standards for protocols and procedures for service delivery used in Kenya.

The importance of standard setting in developing post rape care services: Clear guidelines and standards, including written protocols and procedures for different aspects of the standard of care, at different service delivery points strengthen technical capacities and facilitate services. Client flow pathways in the form of simply described algorithms facilitate internal referrals. Documentation is essential to monitor services.

Stage 4: Capacities development

In this study: At practice level, I identified training needs (6.5) and developed requisite training modules (table 7.3; box 7.3) to fit these needs. Training was cited as key to delivery and acceptability of these services by health providers (8.4.2-5) and to health provider engagement with meso level factors that influence uptake and delivery (8.4).

At policy level, capacity building requirements for the DRH were focused on systems for national training, for institutionalising services, for supervision and implementation on the national policy.

The importance of capacities development in developing post rape care services: Technical and human capacities require on-going evaluation and strengthening. Targeted training that incorporates gender awareness, skills development, and information provision on all aspects of services facilitate health provider appreciation of the need for sensitive and appropriate post rape care. At policy level, standardised training for systems strengthening is critical for sustained service delivery.

Stage 5: On-going technical assistance

In this study: At practice level, I provided on-going technical support and supervision, through on-going consultations with both frontline service providers and managers (7.4). I was thus able to identify district specific needs (7.4) and emerging challenges (7.5) and address them.

At policy level, on-going technical assistance was aimed at supporting development of national quality assurance and reporting mechanisms for continued service delivery.

The importance of on-going technical assistance in developing post rape care services: Challenges, issues, concerns for the programme, for research and for specific situations can be identified and solved. Further, suggestions for improvements can be negotiated with health providers facilitating the quality of care. It is essential that on-going feedback is provided to

the health management through on-going consultations. Gaps identified and lessons learnt during this process form the basis for decision making and further research.

9.4.1 Replication of the 5-stage model for post rape care services development

At the time of writing (April 2007) there were post rape care services in thirteen (13) Government health facilities inclusive of Thika, Malindi and Rachuonyo. The additional sites include:

- The Kenyatta National Hospital in Nairobi which is a national referral and teaching hospital for Kenya
- Two Provincial referral hospitals; the Nyanza hospital, and the Embu Provincial hospital covering for Nyanza and Eastern provinces respectively
- Five District Hospitals (all named after the district); Nyahururu, Siaya, Gusii, Suba, Bondo
- Two sub-District Hospitals - Olkalou hospital in Nyahururu District, and Gatundu hospital in Thika District.

So far, in the thirteen health facilities (inclusive of the study sites that continue to offer post rape care services), 1,920 survivors of sexual violence had been attended to by December 2006.

9.5 My positionality and engagement with this process

I describe tensions that emerged for me in engaging policy. I draw on critiques made on the subjectivity of action research (4.4.4) where it is viewed as a form of political commitment to reflect on my tensions. I also draw on Heale's assertion that utility of research is only tested in application to rationalise my policy engagement focus.

First, the policy engagement process was not framed as a central component of this thesis. However, as indicated in section 4.8 of the methodology establishing services outside of the DRH was impractical. In retrospect the need to engage policy and thus Government was driven by three factors: a) The need to have the results of the study inform policy, particularly after having experienced the increasing demand for post rape care services. I felt that the district hospitals that I was working with should continue to provide services post the study period, and realised that a Government regulatory framework was necessary. b) I was eager

to ensure that policy commitments in national documents[320] did not undergo 'policy evaporation' that I described in chapter 2.4.1. I therefore utilised a strategic framing approach, aimed at mainstreaming gender into health care delivery for sexual violence services (2.7.2; 3.4.2). This I did by extending the LVCT-Government of Kenya collaboration to work with the Division of Reproductive Health. c) The LVCT focus for provision of technical support to Government was influential as I was inured to conforming to the organisational culture.

Secondly, the documentation of the policy work that I undertook did not have a theoretical grounding. Thus, I did not have any specific structure to the policy engagement, and instead utilised two primary approaches.

- I utilised the 5-stage framework (as a model) that I had developed through this study (8.2; figure 8.1) as I felt that it could provide an operational framework for engaging policy (described in 8.3.2). I then applied this model to engage and inform policy.
- I drew on lessons learnt from VCT development by LVCT, to engage the DRH on post rape care development. These included, constant attention to the opportunities presented in policy development processes in order to ensure that sexual violence remained visible, and engagement with other stakeholders given the increasing attention to sexual violence in Kenya (3.4.2). I often demonstrated the increased uptake of services in the study sites as a marker for demand for services.

Chapter 10 The practical and policy requirements for implementing post rape care services in resource-limited settings

10.1 Introduction

In this final chapter I contextualise the use of and draw conclusions on the range of frameworks employed (10.2). I then respond to the study objectives, outlining emergent issues, new knowledge and future directions. I draw conclusions regarding community perceptions and priorities, and the requirements for the delivery of the standard of care (10.3). In 10.4, I present the policy and practice requirements for post rape care services in limited resource settings. I then respond to the broad study objectives outlining the extent to which they were achieved (10.5). Section 10.6 presents the opportunities for strengthening research, policy and practice resulting from this study. In 10.7, I conclude this thesis, by answering the research question.

10.2 Contextualising the theoretical frameworks: feminist epistemologies and gender analysis

In this sub-section I utilise information from the literature, the background of Kenya and the findings in chapters 5, 6, 7 and 8 to discuss intersections and make postulations regarding feminisms, sexual violence and the women's movement in Kenya.

The dichotomy between traditional and modern'/'elite and grassroots' (3.4.1) within the women's movement appears to have been partly precipitated by differences on matters that drew on cultural sensitivities such as marital rape (3.4) and differences over perceived focus, particularly with Western located feminists engaging with the sexuality discourse (2.4). In chapter 5.8.5 I draw on the problematic concept of an 'African culture' that was used by study participants to frame matters that also drew on cultural sensitivities such as dress and sexual practice. In examining these two diverse contexts, I would say that the tensions within the women's movements were but a reflection of the local perceptions regarding culture. It can thus be argued that part of the movement was subscribing to these local perceptions and therefore by extension may have been implicitly sanctioning sexual violence. This may partly

offer an explanation for the limited impact on advocacy regarding sexual violence in the 1980s and 90s (3.4.2). It draws attention to the need for the Kenyan women's movement to internally re-examine positions and build common consciousness regarding 'culturally' sensitive issues. In addition, a paradigm shift around the problematic concept of 'African culture' is critical. There exists an opportunity for re-shaping this concept given its problematic nature as outlined in section 5.8.5.

Socio-political resistances and the emergent dichotomies within the women's movement (3.4.1) appeared to have impacted on the issue of representation, shifting focus from 'what was said' to 'who was speaking' (3.4.1). I see the question of representation as having taken a different dimension over time, from one where the dichotomy was based on the elite/traditional divisions of the women's movements to where the differences were based on a 'professional versus activist' divide. I use the term 'professional' to highlight personnel/position defined by specialised qualification, skill or knowledge in service delivery or policy formulation in support of government. I use the term 'activist' to highlight personnel/position of questioning/criticising state positioning on issues such as gender or sexual violence. Where sexual violence as an issue has been raised and advocated by health care 'professionals' this appears to have initiated government agency, such as was the case presented in this thesis. Thus, the question of 'who is speaking' appears to have taken on a new dimension, where 'professionally' located gender advocates could strategically frame their concerns with greater policy and social impact.

My own approach to responding to sexual violence was framed in the 'professional' context (4.7.3). I drew on multi-racial feminist theory that ideology and commitment to feminism is influenced by social positioning. In retrospect, I utilised the question of 'who is speaking' (though unknowingly) to strategically frame my work within the health sector and thus raise my concerns regarding gendered service delivery for post rape care. The application and impact of strategic framing requires future exploration. This could potentially provide guidance on feminist and gender advocacy positioning.

On the concept of strategic framing (2.4.1), I recognize that I strategically framed my study in the context of feminism in Kenya, gender debates, health care and policy. With reference to Sen's (1.4.2) description of gender, this research demonstrates that gender permeates social institutions (chapter 5), health service delivery structures (5.7.3; 6.6.3) and at a broader level other service providers such as the police etc (5.7.2). A major focus of health care is bio-medical (2.7.2). Most gender frameworks are constrained in that they do not make links between gendered social and structural inequalities to biological outcomes (2.9.3). Despite these shortcoming, I do not provide a response to the question of 'what concepts and strategic frames are most likely to have an impact on advancing gender equity in the health sector'[321] (2.7.2). I also do not provide a response to the problematic broad description of gender mainstreaming and lack of clear tools for making programming operational (1.4.3) Instead, I provide insights into ways in which strategic frames can be utilised to avoid policy evaporation (2.4.1), in order to impact positively on practice within the health sector. *First,* interrogating gendered constructions of health concerns including the bio-medical (micro-level), structural and infrastructural (meso/macro) as part of baseline analysis identifies opportunities for targeted action. *Second,* advocates must be cognizant that the primary interest of the health sector is health care outcomes, particularly in the context of curative medicine (2.7.2). Thus, gender issues must be directly linked to health care outcomes, and where there is theoretical evidence of such linkages, feminist research should seek to draw associations that speak to bio-medicine. *Third,* articulated gender concerns should be integrated into targeted health provider capacity building interventions, vis-a-vis delivering general gender awareness training (6.3). *Fourth,* engagement with providers and training during on-going technical assistance should consistently question, engage and challenge health providers' and managers' own perceptions understanding that they are constituent of broader social perceptions (6.6.2).

Gender analysis provided visibility for an emerging and under-researched area of sexual violence against men and is an important background on which further research on sexual violence against men in Kenya can be explored. For instance, the highly stigmatised nature of sexual violence against men has implications (5.8.4). *First,* there is a negative impact on presentation for care by male survivors, even when the risk of HIV transmission is higher in receptive anal sex than other modes of sexual transmission, and therefore increasing male

vulnerability to HIV infection. In a context where women's sexual decision making power is considerably less than that of men (5.8.1), there is a concomitant increase in women's vulnerability. *Second,* Njue (2005)[258] associates the experience of sexual violence by men with the likelihood of committing sexual violence (3.6). Given the reportedly increasing reports of sexual violence against men (3.3.3) and our data (table 7.1), sexual violence against women will potentially increase.

10.2.1 New operational frameworks for feminisms in Africa are desirable

In the literature, I identified gaps in African located theorising on sexual violence and the ways in which gendered dynamics of sexual violence intersect with the women's movement. This study provides a convergence of data that suggests that even in the Kenyan context, sexual violence is an institutionalised form of control of women that is sanctioned by both women and men (9.3.1). I reflect on radical feminisms that see sexual violence as institutionalised within patriarchy (2.4), a position that has been contested by African located feminists (2.4). Evidence from this study demonstrates that gender mediates the relationship between perceptions of sexual violence and uptake and delivery of care (7.5). The separation of bodily integrity from social processes and institutional development that the African women's movement espouses is therefore unreal and will continue to undermine efforts of advocacy particularly against sexual violence. A paradigm shift in the way that Kenyan located feminisms view and respond to issues of 'body' is required for the desired impact on the prevention, care and rehabilitation continuum. Further the movement requires common consciousness on 'culturally' sensitive issues that appear to have been a constituent part of the tensions within the movement in the 90's. This knowledge opens spaces for Kenyan feminisms to re-define their grounding, in order to be aligned and identified with a common consciousness, a position that the women's movement has been wary of taking (3.4.2). I suggest that alignment and identification with a common paradigm will strengthen the location of sexual violence (and associated issues of bodily integrity) in the public discourse and facilitate response within the continuum.

10.3 Community perceptions of rape in Kenya

The convergence of data in this study: the historical acceptance of sexual violence (3.4.2) as demonstrated in the St. Kizito incidence in Kenya, resistance to women's emancipation on the issue of sexual and other rights (3.4.1), contradictory expectations of sexual behaviour (5.8.2), the tensions of the traditional/modern frames of sexual practice (5.8.2), the primacy of male sexual desire and assumed responsibility for women to fulfil this desire (5.8.2), the potential vacuum in beliefs and values set by a problematic 'African culture' (5.8.5), the legislative shortcomings (3.7), and religious positions (or lack of) on sexual violence (5.8) all intersect. They appear to reinforce each other in ways that are unclear and potentially define pathways through which women's control of their sexuality is socially controlled and/or denied. Sexual practice is thus constructed in ways where the boundaries of force, coercion and consent are unclear (5.3), thus creating spaces where sexual violence is implicitly justified and acceptable (5.8). On the basis of this perspective, I suggest that sexual violence may be viewed as an implicit intentional tool to enforce social order and gender constructions, rather than a deviation from it in the Kenyan community.

10.3.1 Community perceived priorities for a good service

Perceived priorities for a good service for sexual violence survivors that were identified by communities can be framed in the prevention, care and rehabilitation continuum. The need to sensitize communities on sexual violence (5.6) as part of prevention was noted. Care in this thesis was confined to health sector. Long-term support for survivors and rehabilitation for perpetrators was not addressed in this study, thus not adequately covering the rehabilitation aspect of the continuum. These issues form areas of further research. Clearly, a communication strategy that provides information to communities in Kenya is critical to the scale-up of post rape care services. A communication strategy could be aimed at deconstructing sexual violence in Kenya. Feminisms and gender advocates (2.4) appear to suggest women's powerlessness regarding sexual practice. While this view is partly supported by findings in this study (5.2-6), there were emerging constructions of resilience and agency of women to sexual violence. Perceptions that appeared to deviate appeared to be geographically localized and age differentiated (5.8.7). These were not explicitly captured, but emerged briefly as part of the themes (5.3.7). Literature suggests heterogeneity of socialization experiences (2.4) that creates an additional opportunity for deconstructing sexual

violence in Kenya. There is need for further inquiry into these pathways whose potential of being permanent or transient (on the basis of age) is unknown as evidenced by the differences between the older female and adolescent groups (5.8.7). These perceptions that demonstrate agency among adolescent present a window of opportunity for challenging the constructions of sexual violence.

10.4 Policy and practice requirements for post rape care services

This study provides the first evidence for the development of post rape care services. *First,* I determined ***a standard of care*** (box 10.1) in 3 district hospitals in Kenya, whose replicability has been demonstrated by the development of additional services (8.2.2). I demonstrate that a range of services can be packaged to deliver a standard of care following sexual violence in the context of vertical and horizontal approaches, where resources are limited. *Secondly,* I determined the required ***service delivery support systems*** (box 102.) that facilitated the delivery of the standard of care. *Third,* I developed ***model for development of post rape care services*** (figure 10.1) based on the 5-stage framework outlined in section 9.4 that demonstrates how such a standard of care can be developed. This framework gives a platform on which different contexts can base their own service development approaches while making adjustments to cater for context specificity. I was able to transform theoretical inquiry into pragmatic approaches for the health sector response to sexual violence, thus connecting the core reflection process to action outcomes (4.4). I was able to improve survivor care and develop a basis for evaluation of post rape care services in the future, research questions and theory for further inquiry.

Box 10.1 Requirements for delivering a minimum standard of post rape care

Standard of care

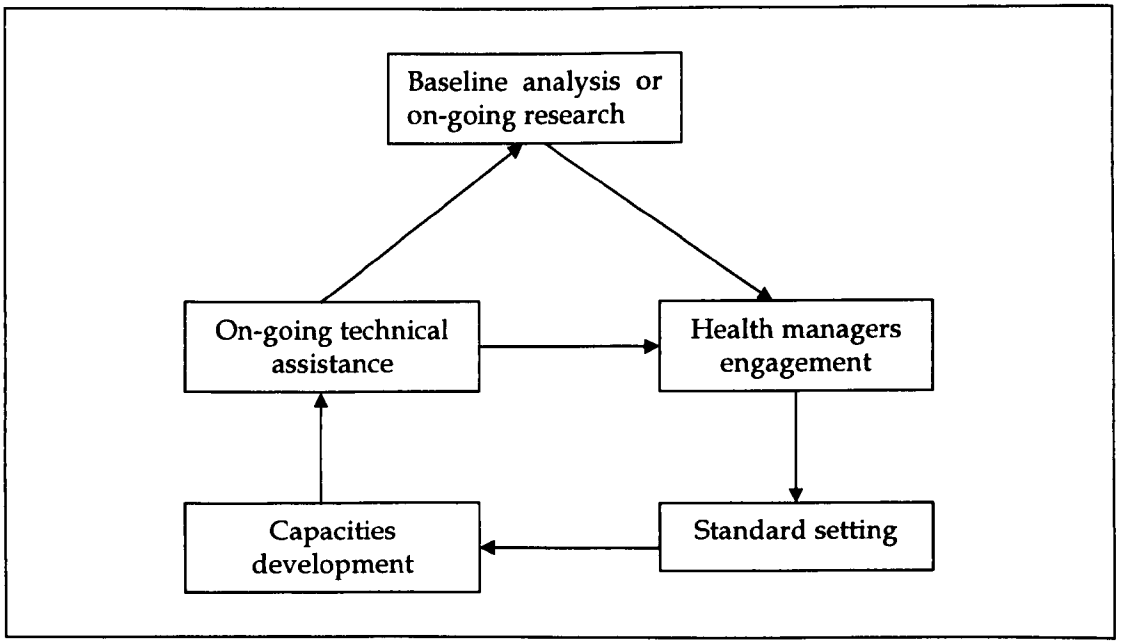
- **clinical evaluation and legal documentation** including
  - forensic/physical examination,
  - collection of evidence, analysis of specimen
  - legal documentation
  - development of an evidence chain that has integrity
- **clinical management** including
  - treatment of physical trauma,
  - prevention of STIs,
  - prevention of HIV
  - Pregnancy prevention
- **counselling** including
  - trauma counselling for survivors and family/partner
  - HIV pre and post test support
  - adherence to HIV post exposure prophylaxis (PEP)
  - preparation for the criminal justice system
- **linkages and referrals** for justice, protection, and on-going social support

Box 10.2 Support systems for post rape care service delivery

Service delivery support systems

- **an algorithm for linking the disparate range of services**
- **streamlined client flow**
- **protocols for all clinical evaluation, legal documentation, clinical management and counselling**
- **capacity building tools and plan for health providers**
- **data and record keeping mechanisms**

Figure 10.1 Model for development of post rape care services



10.4.1 Intersections between social factors and uptake and delivery of post rape care services

While a service was made available, there were many survivors who did not receive the standard of care as intended. The uptake of the standard of care was influenced by social factors (5.8) including the gendered and diverse constructions of sexual violence and stigma (5.8.1-4), a problematic concept referred to as the 'African culture' (5.8.5) and perceived transgression of social norms (5.8.6). The intersections and potential impact of social influences on uptake were further discussed in sections 7.5.2-5.

The delivery of the standard of care was also impacted on by social influences. The bio-medical components (micro-levels) post rape care must be cognizant of the influences of social constructions (meso levels & ecological model), and make them a constitutive part of care as they impact on the outcomes as demonstrated in this thesis (7.3). Systems development (macro) requires health provider awareness and understanding of self and health sector gender unresponsiveness, a set of operating standards and capacity (skill and knowledge). Health providers must also be cognizant of social impact on the quality of service delivered (7.5.5-8).

With specific regard to HIV prevention, HIV PEP delivery needs to be maximised through enhancing completion of medication and HIV testing for survivors. This should provide an opportunity for providing on-going HIV risk reduction counselling, in consideration of other contextual HIV risk that may be non-consensual. In addition, a briefer, targeted counselling intervention that address trauma, HIV testing, on-going HIV risk reduction and PEP adherence, and is supported by an active follow up system is an area for further research.

10.5 Responding to the broad objectives of the study

This study had a range of broad (1.2) and specific objectives (1.3). I fulfilled the broad objectives. I was able to highlight the health related effects of sexual violence and the role of the health sector in the literature (2.5), among service providers in the three district hospitals (6.3) and at policy levels (8.3). In understanding the social constructions using a gender lens, I was able to integrate gender issues within health sector training and responses (6.3). I was able to demonstrate to health providers that sexual violence was a social issue and the health sector had a responsibility to respond through being cognizant of and addressing these social issues as a part of delivery of the standard of care. I harnessed the opportunity provided by the HIV/AIDS debate to utilise existing HIV/AIDS services (VCT for counselling, the HIV care clinic for on-going management of survivors) to develop services. Further, I facilitated integration of traditionally disparate services of counselling and clinical care at the health facility (figure 7.2). The 5-stage framework for the development of post rape care services provided a platform for addressing sexual violence in the health sector. Utilising the results of this study, I was able to harness other advocates to stimulate policy dialogue and debate and develop government interest and commitment in sexual violence (9.2), provide evidence for delivery of a standard of care and support health sector planning.

10.6 Opportunities for strengthening research, policy and practice

Key gaps that emerge in this study include the lack of survivor voices, and the lack of attention to male survivors. While, these issues were not framed for study at the beginning, they form critical issues of debate, their emergence as important issues cannot be ignored. There is need for inquiry into the needs, concerns and experiences of survivors, particularly

where there is availability of services. I can only assume that the relative increase in survivor numbers and uptake of services could be a reflection/surrogate indicator for acceptability of services. Understanding survivor needs and responses to the services offered is a critical basis on which to re-design or/and evaluate post rape care services in Kenya. Plans to scale up services (9.3) by the Government at the moment, lack input of the primary consumers and an emerging vulnerable group. Quality assurance mechanisms require to be developed for this service. Sexual violence against men in Kenya requires further inquiry as well. Approaches to inquiry should include exploring a range of perspectives and experiences from male survivors, and further inquiry into the constructions of sexual violence against men in Kenya.

Impacting on prevention within the continuum requires **better understanding of community located responses**. Research could be used to: a) Explore the opportunities present for deconstructing sexual violence in Kenya. This would serve to inform a community awareness campaign that was constantly identified as a need among study participants (5.7) and among health providers (7.4.5), b) Develop interventions aimed at initiating explicit social sanctioning against sexual violence and, c) Provide information on the effects of sexual violence, increase reporting, instil the immediacy of uptake of post rape care services by survivors.

Strengthening the prevention, care and rehabilitation continuum **requires stronger medico-legal systems**. The health sector is challenged in delivering the high evidential requirements to the justice system Laboratory personnel all sited insufficient training (7.4.5). During this study, I provided limited attention to laboratory standards and service delivery, perhaps due to the artificial separation of the health sector and justice system that I adopted. A key lesson learnt has been the need to strengthen medico-legal linkages as vital to post rape care services. Current gaps include: lack of clear protocols for collection, preservation and analysis of specimen and evidence collected within health facilities, lack of systems for the management and utilization of results from the limited specimen that get analysed, poor mechanisms for transporting the specimens collected from one level of health facility to the next level, lack of clarity of where the mandate for the evidence chain lies. Research should focus on developing and testing a model for a chain of evidence for sexual violence in Kenya, given the resource and capacity limitations.

This study did not facilitate and develop long-term psychosocial support (8.5.6), thus disconnecting care from rehabilitation. There is need for further inquiry to **describe the psycho-social needs of survivors in the context of high HIV prevalence, other contextual HIV risk and limited power in sexual negotiations.** Research is needed to further document and facilitate linkages between social services, follow up systems for referrals and long-term counselling.

HIV PEP provides an opportunity to further strengthen prevention, care and rehabilitation. There is a need to develop and test follow up and retention strategies (8.5.7). This will serve multiple purposes of a) supporting the survivor through trauma and potentially identifying those that require further rehabilitation in social support, counselling or legal aid, b) for medication adherence, c) to facilitate HIV testing follow up at 3 months. Such a study would require to be located within existing health care follow up mechanisms, such as those presented by home based care services that follow up HIV patients on ART. It would also serve to strengthen the linkages between HIV/AIDS and reproductive health services.

HIV PEP can be used as a portal for reduction of on-going HIV incidence among survivors, thus impacting on both sexual violence and HIV. As HIV PEP is increasingly used for sexual violence exposures in high HIV prevalence settings such as Kenya, the moment of presentation needs to be harnessed for lowering HIV incidence by preventing long-term infection among survivors. Research to describe HIV contextual risk of survivors of sexual violence in order to develop targeted risk reduction counselling strategies and utilise the moment of presentation of sexual violence and PEP prescription to leverage on-going HIV risk reduction is necessary. Inquiry to measure adherence and describe factors associated with non-adherence with an aim to develop measures that will optimise on the potency of PEP.

This study **provides the first set of data and information that provides a baseline** through which post rape care services in resource limited settings can be developed in publich health settings and scaled up. It provides a basis on which evaluation of post rape care can be undertaken.

10.7 Conclusion

Despite the challenges of this study, it has made a substantial contribution to availability of post rape care services, health sector policy and response on sexual violence in Kenya. Most fundamental these changes are entrenched in policy, with written Government commitment, and action, and thus offer the potential for sustainability.

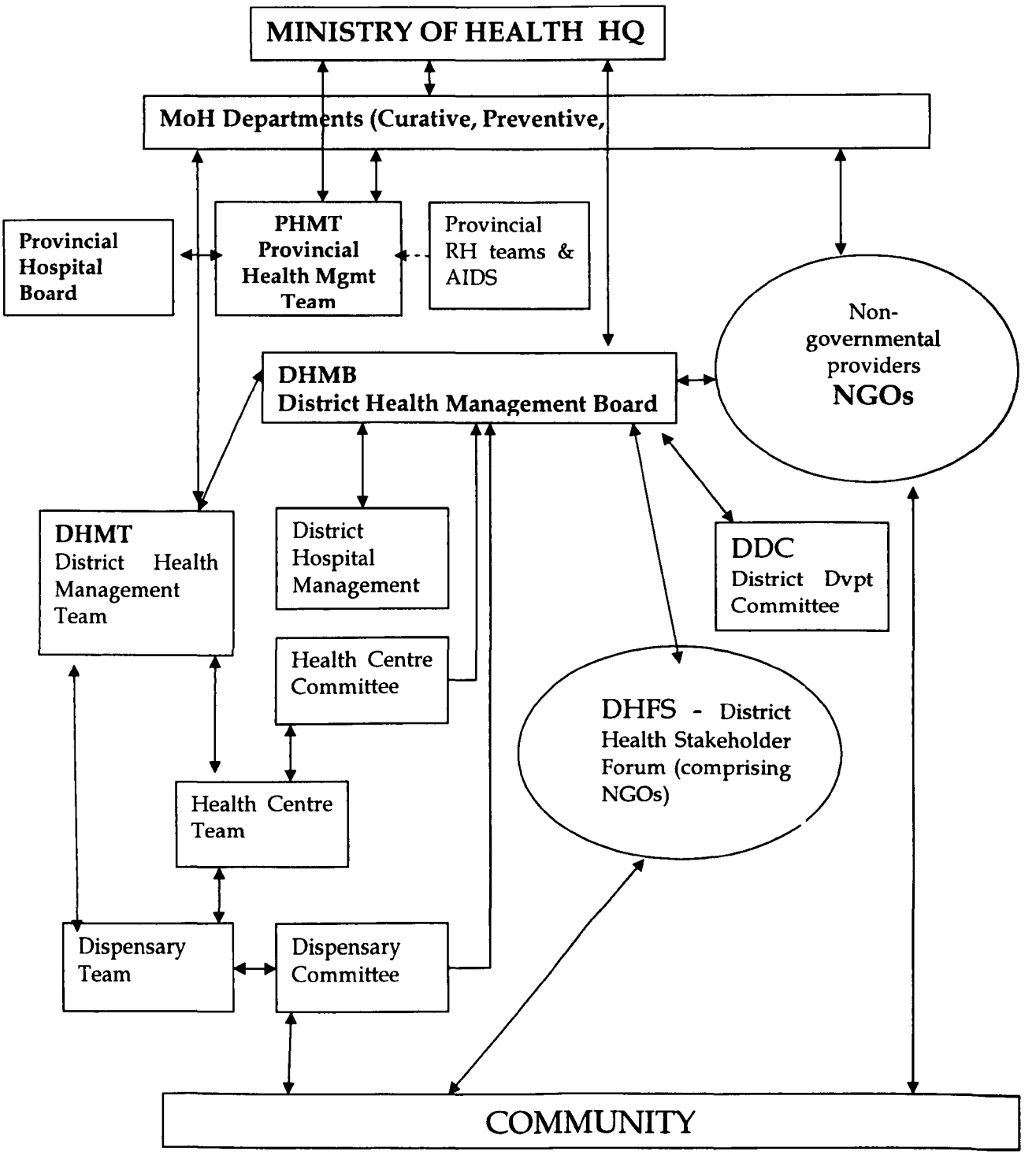
This study contributed to the identified need for evidence-based, context specific interventions for providing sexual violence services raised in literature. Drawing on the rationales of this study, evidence in this study demonstrated that the perceptions of sexual violence in Kenya do influence both the uptake and delivery of services (5.8; 7.5). It is essential that sexual violence interventions, including those that are bio-medical (micro-level) understand existing historical and social location, and gendered constructions. They also need to recognise that these influence community level (micro/meso) and institutional (meso/macro) responses. This study has demonstrated that sexual violence is normative sexual practice in Kenya. Thus, separating issues of bodily integrity from social and institutional processes undermines all efforts in prevention and response to sexual violence. Feminist/women's movements in Kenya need to acknowledge this position, not as emanating from Western located feminisms, but as a local reality that demands response. In order to holistically impact on the prevention, care and rehabilitation continuum, Kenya must develop social interventions that are purposed to deconstruct sexual violence and shift perceptions of normative sexual practice towards explicit social sanctioning against sexual violence. Such interventions need to be informed by feminist approaches and strategically framed to respond to social practice and relevant policy in Kenya. However, while many responses to sexual violence are needed outside of the health sector, it is the health sector that sits squarely at the nexus of prevention and care, and provides the primary evidence for the criminal justice system. The health sector must therefore take responsibility to meet the health needs of survivors of violence.

In this regard, this study demonstrated that the 5-stage framework used for development of post rape care services increased uptake and delivery in the health sector in resource limited setting. It was further utilised to expand services in Kenya, and to develop and implement policy action. Data demonstrates links between social perceptions of sexual violence and

health outcomes, creating an imperative for health sector action. Thus, it is essential that gender considerations are made part of health care planning and delivery. This is possible through: training that examines the impact of health provider perceptions and empowers providers to shift their attitudes; through delivery of counselling and clinical care in ways that accommodate the difficulties caused by shame, blame and stigma of sexual violence and HIV among survivors and through development of counselling and treatment protocols that acknowledge and address risks posed by sexual violence in the context of blurred boundaries between forced and consensual sex. The opportunities for HIV PEP interventions to strengthen broader HIV prevention efforts must be harnessed. At the meso/macro level, their success lies in de-fragmenting services so that clinical and counselling care are complementary as this has the additional benefits of positive bio-medical outcomes. At the micro/meso level, counselling programmes should draw on the ecological model of sexual violence, to facilitate development of on-going risk reduction measures that appreciate individualised vulnerability to sexual violence and contextual risk to HIV. Finally, this study has demonstrated that strategically framed advocacy, backed by research can have positive impact in positioning gender issues that draw strong cultural sensitivities within public, social and policy spaces. This creates opportunities for new debates which offer alternative avenues for promoting advocacy for gender equality within the health care sector.

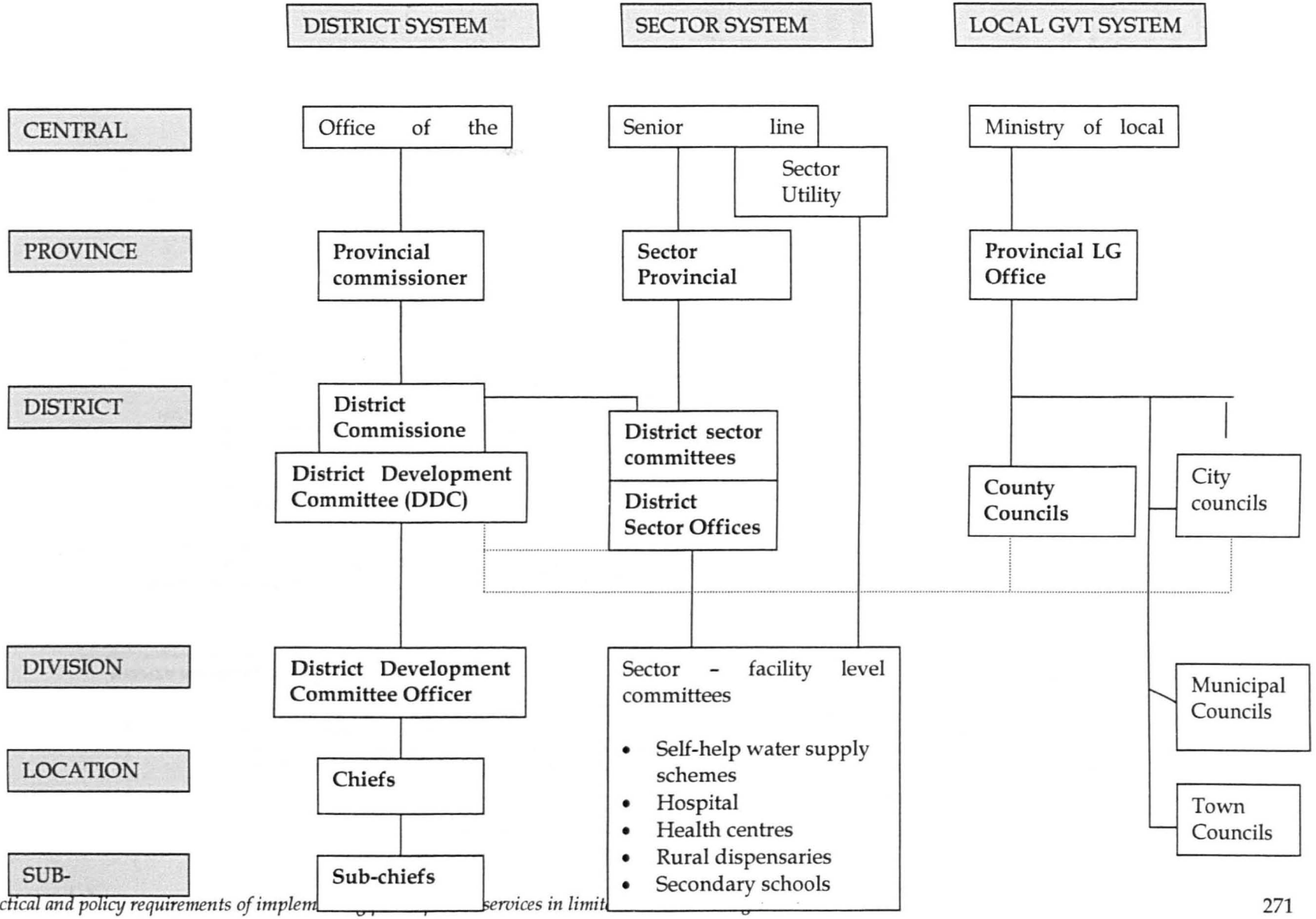
Annex 1 - Decentralised Health Services Organogram

Adapted from: Asienwa B / MoH, 'Documentation of Health Sector Reforms', Final Draft, January 2002

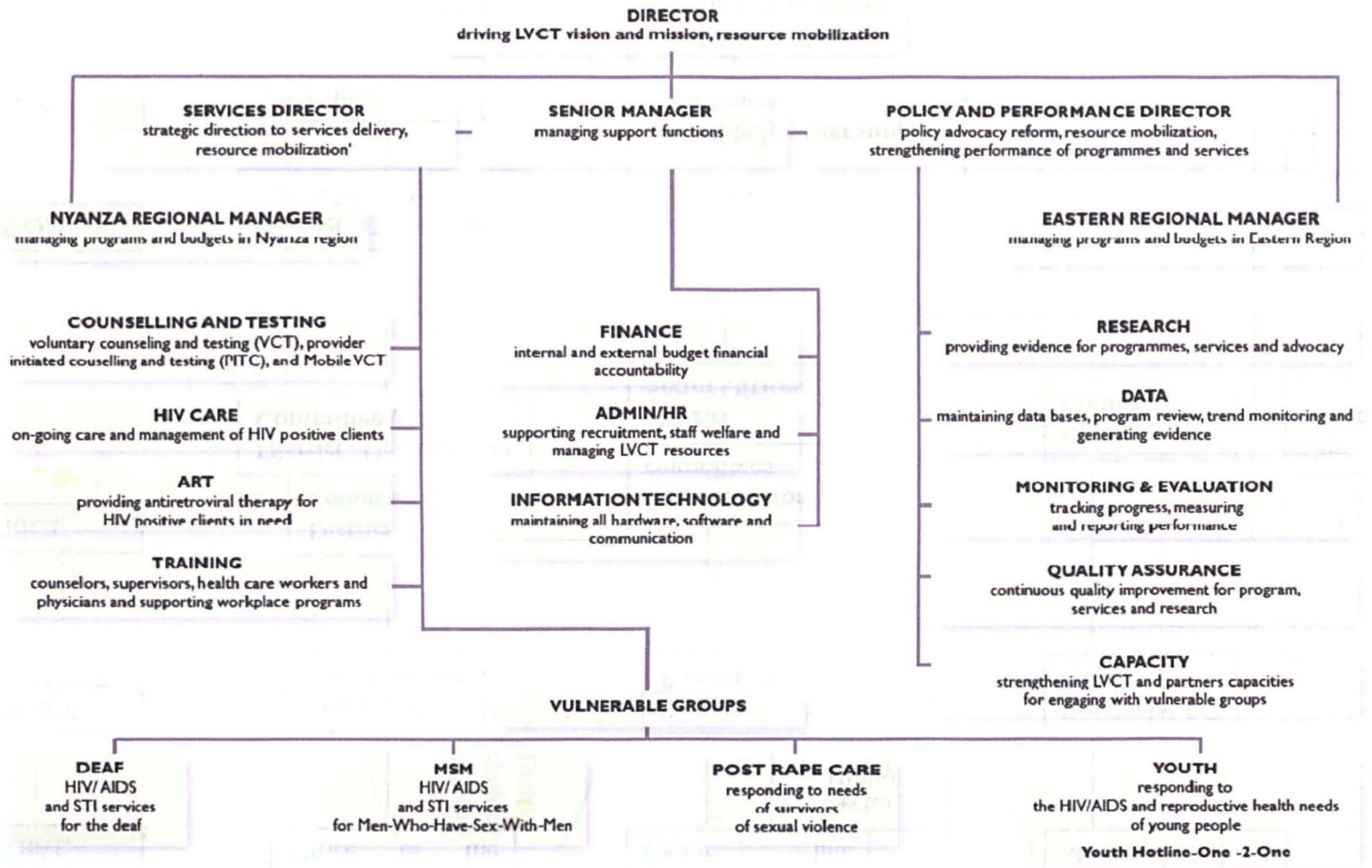


Annex 2 – Parallel Systems for Delivery of Local Services in Kenya

Source: WB/DFID 'An assessment of local service delivery and local governments in Kenya', Unpublished Final Draft, May 2002.



Annex 3: LVCT current organogram



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Annex 4: Focused Group Discussion Guidelines – Baseline

Notes:

- Based on the information needs we identified, please practise the FGD with these questions.
- Understand them, test them and see how they can be applied.
- Feel free to make any changes, modifications, etc that we can discuss after the practise sessions

General opener

What do you know about HIV??

Probe for methods of transmission and tease out sexual violence (rape/sodomy) as one mode of transmission

Keep in mind that this is a sensitive and potentially expolosive area surrounded by norms, taboos, beliefs and stigma. It needs to be approached with caution and the counsellor should be able to read the group.

Read ⟶ *Think* ⟶ *Act*

What do you understand by rape/sodomy? Probe – keeping in mind the following questions

Probe about whether it happens here? Keep these questions/issues in mind.
Are there any links between HIV and sexual violence? If so, what?

Remember, if there were some cases identified, the moderator could use these as a reference point and make connections to the normal occurrences

How are cases/situations resolved?

Were/are they reported to the police or/and taken to hospital or VCT site
In what circumstances are they reported to the police?
Who does/did the reporting?
What happens at the police station?
Who accompanies (d) the raped person?
What happens at the hospital? Are the staff there supportive?
Are there any charges for these services?
Are there any extra costs?
How affordable are these?

Do you feel that the police are/were helpful?
What can they do to be more helpful?
What can they do to be more helpful?

What other services and support is available in the community

What other organizations/institutions provide support to rape survivors in the community??
What sort of support is provided??
What type of support should they be providing??
What constraints are faced by those who have been raped and their families?

In your opinion what can be done

What can be done to minimize these constraints?
What can be done to stop rape?
Who should be involved? And how?

Keep VCT in mind at this point so that if it comes up in the discussions, it can be followed up and if not, remember to ask whether VCT has any role in this.

What is VCT?
Do you think it is useful?
If so, how?

Annex 5: Tools for Key Informant Interviews at baseline

KEY INFORMANTS DISCUSSION GUIDELINES

FOR RESPONDENTS FROM THE CRIMINAL JUSTICE SYSTEM

i. What is the definition of rape in Kenya?
ii. What other definitions exist in the law with regard to sexual offences?
iii. What does the law say about rape??
iv. What are the laid down procedures and requirements for rape reporting
v. What is the procedure for prosecution??
Probe... description of a step to step guide on what a person who has been raped should do?? Who can give admissible evidence in court – clinicians, doctors, counsellors, minors
vi. Do you think that this system is functional??
vii. What needs to be done to enhance this system??
viii. There are many people who are involved in rape cases – police-doctors-advocates-judicial system etc
Probe... Do you feel that they have the required competency in knowledge and legal requirements and processes to support survivors?? What should be done??
ix. In what ways can legal support groups engage law enforcement towards addressing rape as an issue?
x. What is the responsibility of the Government towards provision of legal support to rape survivors??
What makes you think so?
xi. In your opinion, are the legal provisions we have for support of rape survivors adequate?
xii. What are the constraints/challenges that rape survivors face from a legal perspective??
xiii. What can be done to get more people to report and seek post-rape services??
xiv. What are the constraints towards provision of adequate legal services?
xv. What are the opportunities?

TO SPECIFIC ORGANIZATIONS

xvi. What is the responsibility of legal support organizations towards rape survivors who come to you for your services?
xvii. Are there any conditions for support of clients?
xviii. What legal services do you offer your clients?
xix. What other/support services do you offer the clients?

IN DEPTH INTERVIEWS WITH THE POLICE

i. What is the definition of rape in Kenya?
ii. What other definitions exist in the law with regard to sexual offences?
iii. What does the law say about rape??
iv. What are the laid down procedures and requirements for rape reporting
v. What is the standard procedure in the event of a person reporting assault/rape??

Probe... is the procedure has been written down and whether it is followed? Where is it written? Can this be accessed?

vi. Are there specific questions/issues that you are supposed to ensure that you capture when during reporting??
vii. After rape has been reported to your stations, what specific actions do you undertake?
viii. What does the law say about investigation and prosecution in rape cases? Requirements, laws,
ix. What is the role of the police in this process??
x. Do you feel that the police accomplish this role as stipulated by law?? What makes you feel so??
xi. Do you felt that the police accomplish this role as expected by the public?? What makes you feel so??
xii. Do you refer rape survivors once they report to you?
xiii. Where do you refer them??
xiv. How many rape cases were reported in this station in the last one year? Two years??
xv. How many of these rape cases were you able to prosecute??
xx. What is the responsibility of the Government towards provision of legal support to rape survivors?? What makes you think so?
xxi. What in your opinion should the police be offering to support rape survivors??
xxii. In your opinion, are the provisions we have for support of rape survivors adequate?
xxiii. What are the constraints/challenges that rape survivors face from your perspective??
xxiv. What can be done to get more people to report and seek post-rape services with the police??
xxv. What constraints do the police face in delivering services to rape survivors?
xxvi. What opportunities do you see in enhancing service provision?

IN-DEPTH INTERVIEWS WITH RESPONDENTS FROM THE HEALTH SECTOR

i. What is the definition of rape in Kenya?
ii. What other definitions exist in the law with regard to sexual offences?
iii. What does the law say about rape??
iv. What are the laid down procedures and requirements for rape reporting/presentation?
v. Is there a standard rape management protocol used??
From the MoH, KMA, WHO etc
Probe... Do you have any comments on this protocol - modifications, alterations etc
vi. Have you heard about the evidence collection kit from KMA??
Probe... What do you feel about it?? - is it fine, does it need modification?? In what way??
vii. Is there a standard forensic/physical examination procedure??
Probe... Do you have copies of the procedure?? Have you seen it?? Do you know where I can get it??
viii. Who is supposed to do the tests??
ix. In institutions where are they generally done??
x. What happens to the samples?? Where are they stored?
By who??, To whom can they be availed??
xi. What is the system for maintaining the 'chain of evidence'??
xii. What is the general practice in the provision of post rape service
- Once the client reports to the police station?? To the hospitals??
- During examination
- In follow up support

xiii. Are there an existing PEP provision guidelines and/or national protocol??
Probe... What other regimens are being offered for post rape to reduce risk of transmission of HIV?
xiv. Is PEP being provided as part of rape services??
Probe... if so, Who is offering PEP?? Public institutions, private institutions? What is offered? Who can access it? How much does it cost?
xv. What in your opinion is the capacity for ARV prescription and administration in Kenya??
Probe... Are Doctors/clinicians generally trained in HIV care and management?, test requirements for PEP provision,
Can these tests be done in any public hospitals,
Is there any existing training package in the country for already practicing Doctors/clinicians??

xvi. Are there any adherence to PEP issues, you see arising??
Probe..... which ones?? How can they be dealt with??
xvii. What support can be given to clients to enhance adherence to drugs??
xviii. Any ideas of follow-up mechanisms that may be put in place to support the client and enhance adhereance??
xix. Given that a number of rape clients visit VCT cnetres for support, what could be done to provide/support post rape services within VCT sites??
Probe... Clinical management?, examination??, counseling??,

IN-DEPTH INTERVIEWS WITH RESPONDENTS IN COUNSELLING, REHABILITATION AND SUPPORT SERVICES

i. What is the definition of rape in Kenya?
ii. What other definitions exist in the law with regard to sexual offences?
iii. What does the law say about rape??
iv. What are the laid down procedures and requirements for rape reporting
v. Do we have adequate counseling services for rape and subsequent trauma in Kenya and in our hospitals??
vi. Who/where are these services being provided??
vii. Who is providing the training for counselors??
viii. In your opinion, are rape survivors adequately supported in counseling??
Probe for feeling and what more needs to be done, who should be involved in doing it??
ix. Infrastructure for counseling support??
x. What other support is provided from counseling institutions - advise on legal systems?? Advise on
xi. Who provides counseling supports
Probe.....e.g Government hospitals, churches? Names of any specific ones??
xii. What referral mechanisms are in place between counseling organizations and other rape care service providers??
Probe...Does anything need to be done to enhance referral?? If so what?? Who should do it?? What is their responsibility??
xiii. Given that PEP goes hand in hand with HIV testing, what in your opinion should be done to:
Probe...Reduce trauma?? Prepare the client adequately for the possibility of sero-positivity at this traumatic time?? Increase capacity of counselors for dealing with double trauma of clients
xiv. What in your opinion is the responsibility of the government towards support of rape survivors??
xv. What systems should be institutionalized to enhance counseling and support for rape survivors??

GENERAL QUESTIONS TO ALL KEY INFORMANTS

i. Are you in any way working with partners of your clients?
   If so, how?
ii. What other activities are you involved in? (policy dialogue, etc)
iii. What challenges do you face on a day to day basis?
iv. What linkages do you have with different service providers?
v. Do you have any follow up/tracking mechanisms of your rape survivors?
vi. What in your opinion is the responsibility of the health system towards its GBV clients?
vii. What in your perception is the responsibility of law enforcement and judicial system for rape survivors?
   Is this responsibility being carried out effectively? Why do you think so?
viii. What are the constraints/challenges to provision of adequate support services to your GBV/Sexual assault clients?
ix. What are the opportunities for provision/ improvement of these service?

Annex 6: Casualty Record

Reporting (presentation)		Name	Age	Sex	Date & Time of alleged assault		Seen by C/MO nurse	P3 filled	Police officer sign	Physical examination	Given 1st dose of		Referred				Person filling form	Comme
Date	Time				Date	Time				insert patient card no.)	EC	PEP	CT	STI	Labs	PEP follow up	Signature	

Notes:
C/MO - Clinical/Medical Officer
CT - Counselling and testing

Annex 7: Laboratory Record

Name	Lab. no	Arrival at lab		Age	Sex	Specimen	Specimen collected by	Time of analysis	Date of analysis	Results	Gram stain	Analysis done by	Police collecting results
		Time	date										

Annex 8: HIV Care Clinic Clinical Record for Post-Rape Care & NSSI

Name ☐ Reg.number: ☐

Age ☐ Weig ☐ H ☐ ☐

	Date	Time	Department
Time of injury	/ /	:	----------
Arr. at TDH	/ /	:	Casualty ☐ OPD ☐ VCT ☐ Other ☐
Arr. at PEP clinic	/ /	:	----------
1st dose of PEP	/ /	:	Casualty ☐ OPD ☐ VCT ☐ Other ☐

Presentation to PEP time: ☐ Injury to PEP time: ☐ (PEP not indicated after >72hrs)

PEP not given: ☐ Reason:

(A) For Rape Survivors:

(1) Assume assailant is HIV positive - if presents before 72hrs offer first dose of PEP as soon as possible, if not already given - PEP can be given safely for up to 3 days until the individual is psychologically ready for DCT/VCT and baseline bloods - go to (2)

(2) Have the following been offered? (if "no" then refer if appropriate)		**Accepted?**	**If not referred or accepted-reason?**
Emergency Contraception?	Yes☐ No☐	Yes☐ No☐	
STI Prophylaxis?	Yes☐ No☐	Yes☐ No☐	
Forensic Examination?	Yes☐ No☐	Yes☐ No☐	
Trauma Counselling?	Yes☐ No☐	Yes☐ No☐	

(B) For HCW after NSSI:

Have they presented or already started PEP within 72 Hours of the Injury?

No ☐ - PEP not indicated - offer VCT, counsel on avoiding future NSSI, NSSI 1st Aid

(3) Is the HIV status of the source known? No ☐ - incl.unknown source - see (5)
Yes ☐ - see (4)

(4) Source Patient HIV Status is: Negative ☐ - consider window period - see (7)
Positive ☐ - Offer PEP - see (8)

(5)Will source patient consent for DCT? No ☐ - Assume source is Positive - Offer PEP
Yes ☐ - go to (6)

(6) Source Patient is HIV Negative ☐ - consider window period - see (7)
HIV Positive ☐ - Offer PEP - see (8)

(7) Explore risk factors with source patient about whether it is possible they are in the "window period"

Not in window period ☐ - PEP not indicated - reassure client
Could be in window period ☐ - Offer PEP - see (8)

NB: If waiting for source patient testing will delay PEP, it is better to offer first dose before this.

(8) Refer client for CT - Refuses? ☐ - not eligible for PEP
HIV Negative ☐ - continue PEP for full 28 days
HIV Positive ☐ - discontinue PEP and explain –
(refer for further counselling, for HIV care – explain infection as pre-existing, not this episode)

HIV Status	Baseline	4/6weeks	12 weeks
NEGATIVE	☐	☐	☐
POSITIVE	☐	☐	☐
DID NOT ATTEND	☐	☐	☐

Monitoring Blood Tests

	Normal Range	Base -line	Tick if Normal	After 2 wks	Tick if Normal
Date	-	/ /	-	/ /	-
Hb	>11		☐		☐
WBC's	-		☐		☐
Neutrophils	-		☐		☐
Platelets	-		☐		☐
Creatinine	<1.4		☐		☐
SGPT	<35		☐		☐

Drug regimen

Weight /Kg	Regime	Tick
>40	AZT/3TC combined One tablet BD	
20-40	2x100mgAZT BD + 1x150mg 3TC BD	
10-20	1x100mg AZT TDS + ½ x150mg 3TC BD	

Comments _____

Planned date of next Appt.	Started	/ /	/ /	/ /	/ /	/ /	/ /	Side Effects
Actual date	/ /	/ /	/ /	/ /	/ /	/ /	/ /	1. Rash
No. doses dispensed today								2. Nausea
No. of tablets remaining	-------							3. Vomiting
No. that should be remaining	--------							4. Diarrhoea
Last time missed a dose?	--------							5. Muscle Pain
Reason?	--------							6. Pins&needles
Client referred for counseling?								7. Headaches
Client received counselling?								8. Insomnia
								9. Fatigue

Comments & on side effects _____

OUTCOME
Was the full 28 day course completed? YES☐ NO☐
Number of days of PEP completed ☐
Reason for discontinuation? Defaulted/not known☐
Side effects ☐
Toxicity ☐

Notes: _____

Annex 9: Collated Post Rape Care data entry form

(Next page)

e: Study No: Client serial No:

rict No: Client Surname:

ge (years)

ex

Female 2 Male

Weight (kg)

njury

e (dd/mm/yy)

e (hours/mins)

rrival at District Hospital

e (dd/mm/yy)

e (hours/mins)

oint of presentation

Casualty if yes, casualty number?

PEP/CCC clinic

OPD

V/DCT

ther (specify)

What was presented

Sexual Violence/Rape

Occupational Exposure

ther

Disability

Mental 4 Visual

Physical 5 Non-communicable

Hearing

ther

EP Administration

ry to door time (arrival – injury time)

/mins

Presentation: <72 hours?

Yes 2 No

Was 1st dose of PEP given?

Yes 2 No

es, when

e (hours/mins)

e (dd/mm/yy)

Injury to dose time

dose – Injury time)

/mins

e (dd/mm/yy)

Door to dose time

dose – Injury time) hrs/mins

Was EC given?

Yes 2 No

o why

15. Was the assailant known

1 Known with blood relations

2 Known with no blood relations

3 Not known

4 Not indicated

9 N/A

Indicate No. Of Assailants

More than 1

16. If SV/Rape, what type?

1 Vaginal penetration

2 Anal penetration

3 Oral penetration

4 Multiple penetrations

9 Other (specify)

17. Was forensic examination undertaken

1 Yes 2 No 3 Not known

18. Was the Casualty form 1 form filled?

1 Yes 2 No

If yes, cas. number

19. Arrival at PEP clinic

1 Yes 2 No

If yes, date?

PEP clinic number?

20. STI prophylaxis/management offered

1 Yes 2 No

3 Not indicated/known

21. Were lab services provided

1 Yes 2 No

If yes, client lab no.

22. Was reporting done to the police

1 Yes 2 No

23. Did the police collect and sign for any specimen taken from the hospital

1 Yes 2 No

3 Not known

24. Was counselling for trauma and for HIV testing offered

1 To the client

2 To the guardian of the client

3 No

4 Not indicated/known

25. HIV baseline test undertaken

1 Yes 2 No

26. If yes, HIV test results

1 HIV +ve 2 HIV –ve

27. Blood monitoring tests

Hb1 1 Yes 2 No

Creatinine 1 Yes 2 No

SGPT/ALT 1 Yes 2 No

28. Was client continued on PEP

1 Yes 2 No

29. If PEP was discontinued, why

1 HIV Positive

2 Abnormal bloods

3 Did not return to clinic

9 Other (specify)

30. Follow up counselling at 7/7

1 Yes 2 No

31. PEP/CCC follow up at 2/52

1 Yes 2 No

32. Follow up counselling at 2/52

1 Yes 2 No

33. PEP/CCC follow up at 4/52

1 Yes, Date:

2 No

34. PEP completed? (28days)

1 Yes 2 No

35. If No, why?

1 Discontinued by clinician

2 Self discontinued (explain)

3 Toxicity

4 Not known

36. PEP outcomes at 4/52

1 HIV –ve 2 HIV +ve

3 Not known

37. Follow up counselling at 4/52

1 Yes 2 No

38. PEP/CCC follow up at 6/52

1 Yes, Date:

2 No

39. PEP outcomes at 6/52

1 HIV –ve HIV +ve

3 Not known

40. Follow up counselling at 6/52

1 Yes 2 No

Annex 10: Tool for Measuring Health Provider Acceptability

FOR KEY INFORMANT'S CHECKLIST AT THE HOSPITAL: discussion guideline 1

- Depth interviews:
- Target group: The District MOH, The Nursing Officer (matron), DASCO, The laboratory officer (Health managers)

xx. Are you aware of the post rape care services in this institution?

xxi. What do these services entail? What is the protocol for management of a rape survivor that this hospital uses?
(probe for information on the procedures and processes undertaken at:
- casualty, OPD, laboratory, HIV care clinic and VCT/DCT counselling)

xxii. Do you feel these services are adequate for survivors and manageable by the hospital on a long term basis? *(Probe: drugs availability, affordability, labs testing, which of the procedures could be altered, what could be reduced or what needs to be added??)*

xxiii. Do you feel that the staff in this department *(for departmental heads)*/ in the different departments *(for other key informants in the hospital)* have the required capacity to provide the services you have detailed above??
(Probe for explanations, why the person thinks so and what they feel could be done to improve this)

xxiv. What do you feel about the coordination of the services described above?
(Probe: Who is responsible for coordination? Who makes decisions on PRC? What are the challenges for internal referral between the different departments and what can be done to address these?)

xxv. Are there existing linkages between post rape care services provided in this hospital other required services such as the police?? legal support, children services, social services??
(Probe: are these formal? Who is responsible for them? How do they function etc?)

xxvi. What happens with P3 forms in this hospital?
(Probe: who fills them? how often?, are they bought?, does the survivor pick them from the station? Do they have to be accompanied by the police? Who is responsible for answering court summons on P3 forms)

xxvii. What is the information collection and recording system for post rape care?
(probe: What records are kept, who keeps them, for what purpose, are they integrated into the district health management and information system? What are the challenges?? What could be done to address these?)

xxviii. What do you feel are the hospitals strengths in the provision of comprehensive PRC
xxix. What are the challenges to the continued provision of comprehensive post rape care in this hospital?
xxx. How can PRC be improved and made sustainable in this hospital? And in health facilities in other parts of the country as well?

FOR KEY INFORMANTS AT THE HOSPITAL: discussion guideline 2

- Depth interviews
- Target group: Actual front line service providers in each of the relevant departments of the district hospital - 1 hospital doctor (preferably involved in post rape care, 1 HIV care clinic CO, the nurse in charge in casualty, the pharmacist, 1 trauma counsellor, 1 lab-technician)

i. Are you aware of the post rape care services in this institution? Do you think other people within the hospital are aware of these services?? (probe on why the person feels so, what can be done?)

ii. Do you feel that these services are known by the public?
(probe on reasons why person thinks so, what can be done to enhance access to these services)

iii. What do these services entail? What is the protocol for management of a rape survivor that this hospital uses?
(probe for information on the procedures and processes undertaken at:
- casualty, OPD, laboratory, HIV care clinic and VCT/DCT counseling, what is known on internal referral mechanisms and how they are undertaken)

iv. What aspects of post rape care are provided in this department:
(Probe: the exact procedures and processes undertaken here, why are the procedures you have described here undertaken in this way? For how long has this department been involved in the provision of these services, how long have records been kept) -

Specific areas to note for each department: Can the respondent give you more information about... *For casualty and OPD* - ***The rape register*** - ***PEP provision*** - ***EC provision*** - ***Examination and documentation of the survivor of violence including HVS*** - ***Where documentation is done*** - ***Referral??*** **Who undertakes these procedures?** **To where are people referred?** **Rationale behind these procedures?**	- ***Protocol? (knowledge and awareness)*** - ***Where are persons referred?*** - ***HIV testing??*** - ***Post rape counselling data form*** *At Laboratory* - ***Rape register*** - ***Tests undertaken??*** **-To whom are results given?**
At the HIV care clinic - ***PEP provision*** - ***STI treatment*** - ***The PEP clinical form*** - ***Blood requests (SGPT/ALT, HIV test)*** **-Where are persons referred from here?** **-why these specific procedures** *At the VCT/DCT site*	

Remember to query:

- *Reasons why things are done as they are??*
- *Who is responsible for specific activities mentioned?*
- *How long these activities have been undertaken?*
- *What is different from what was done before and what the respondent feels about these changes)*
- *What records are kept, who keeps them, for what purpose, are they integrated into the district health management and information system?*

v. Do you feel that you and other members of this department have the necessary capacity to deliver these services? What could be done to support the development of necessary capacity?

vi. What do you in this department do about those circumstances that require other post rape services that are now available at the hospital such as the police?? legal support, children services, social services??
(Probe: for referrals? are these formal? Who is responsible for them? How do they function etc?)

vii. What do you feel are the challenges for provision of PRC for this hospital?
viii. What do you feel are the challenges for this department with regard to providing PRC
ix. What could be done to address these challenges??

Annex 11: Checklist for physical examination

EXAMINATION OF SOMEONE WHO HAS BEEN SEXUALLY ASSAULTED
(this was enlarged bolded and placed on clinic walls)

Have I undertaken and recorded my physical examination?

BRUISES - (note colour - blue, yellow); ABRASIONS AND TEETH MARKS for the following areas:

1. **Hair**
2. **Mouth**
3. **Neck**
4. **Breasts**
5. **Torso**
6. **Arms**
7. **Perineum**
8. **Anus**
9. **Vagina**
10. **Legs and feet**

Have I taken the following samples?

1. **Serum**
2. **Hair combings**
3. **Saline swab of semen in the mouth**
4. **Nail scrapings (use a toothpick)**
5. **Saline swabs of any teeth-marks**
6. **Anal swab before vaginal swab to avoid cross-contamination**
7. **High vaginal swab**

Have I labelled my samples (samples for lab and samples for the police)?

1. **Date of examination**
2. **Name of survivor**
3. **Card number of survivor patient card**
4. **Analysis requirements for the laboratory**
5. **Own signature**

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