Utilization of a multi-sectoral approach in strengthening cross-sectoral referrals of survivors of sexual violence from the health sector in Kenya

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DECLARATION

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ABSTRACT

Background: Sexual violence policy frameworks and service delivery models are well defined in Kenya. However, little is known about the extent to which different sectors effectively work together to ensure survivors receive comprehensive care. The need for a multi-sectoral response framework has been cited in the literature. Nonetheless, it is not clearly defined what this entails in the Kenyan context.

Aim: This thesis aimed at reviewing and documenting the processes involved in the delivery of services by the different sectors with a focus on patient flow, data systems, community perceptions and referral mechanisms The study also aimed to develop an in-depth understanding of the factors that influence reporting of cases of sexual violence, provision of services and uptake of available services. Also explored were the requisites for a coordinated and multi-sectoral approach to sexual violence.

Methods: This is a cross-sectional study that applied a mixed-methods approach. Qualitative interviews were conducted with 23 service providers, survivors and caregivers. The quantitative component entailed abstraction of service statistics from records maintained for survivors. A total of 1259 records were obtained from two hospitals, two police stations and two courts in two counties in Kenya. Key informant guides were used for the qualitative interviews, while an Excel data abstraction tool was implemented to capture data obtained from service statistics. Thematic analysis of qualitative data was undertaken using NVivo 12. The records were analysed using SPSS Version 20.0 The Anderson model (1973) informed the interpretation of the qualitative data. Data were triangulated during the analysis across the interviews and service records.

Findings: Defilement constitute the largest proportion of cases of sexual violence reported across different sectors. Poor quality of sexual violence data maintained for survivors across different service delivery points presents a difficulty in tracking survivors to examine completeness in service uptake. Existent difficulties persist in determining the extent to which the different sectors are responsive to the survivor's need for quality and comprehensive services. Survivors--more so female and children--do not have autonomy in decision making regarding whether to report a sexual violation meted on them or not. Lack of a standardized multi-sectoral referral framework contributes to survivor frustration in accessing services due to the multiple referral pathways, costs and time delays involved. There is continued reliance on informal community level arbitration of cases despite the existing legal provisions in the Sexual Offences Act.

Conclusion: The Anderson (1973) framework provides a basis for an in-depth understanding of survivors' service utilization related behaviours and decisions. The findings reveal the interconnectedness of predisposing enabling and need factors in the context of the available services and decision making on what service to take up. While the health sector and police continue to play a key role in response to sexual violence, there still exist gaps that impede the comprehensiveness in response. Communities still prefer reaching out to informal sources of support. However, there is a disconnect between formal and informal sources of support. The need for a multi-sectoral and coordinated approach to sexual violence is critical, and its design should be informed by the needs of survivors. Measures should be put in place to address enabling factors to service access through training of providers on the management of survivors. This study provides anecdotal evidence to be utilized in informing

development and implementation of multi-sectoral models of post-sexual violence service delivery models in Kenya and in Sub-Saharan Africa.

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Definition of Terms

Healthcare Worker - Refers to anyone who within the health sector has undergone health-related training and has received certification either as a nurse, social worker, clinical officer, laboratory technologist, counsellor or as a doctor. This term has in this thesis been used interchangeably with the term health care provider.

Multi-sectoral Approach – This is the holistic inter-organizational and inter-agency efforts designed to facilitate collaboration and coordination across key sectors, including (but not limited to) health, psychosocial, legal/justice and security.

Perpetrator-- An individual who has committed a sexual violation

Sexual Violence - Various terms have been used globally in research, programs and policies to describe forced sexual contact. Some of these terms include sexual assault, sexual violence, sexual offences, violence against women, and sexual and gender-based violence. In this thesis, I adopt the definition by the World Health Organization wherewith sexual violence is defined as, "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object." Sexual violence in the context of this thesis is used to refer to any sexual offence and/or assault that involves coerced contact with an individual as defined in the Kenya Sexual Offences Act (No. 3 of 2006).

Survivor - An individual who has experienced sexual violence. Within the legal justice system in Kenya, the term "survivor" is interchangeably used with the term "victim." However,

generally, the use of the term “survivor” is considered more sensitive, hence its wide utilization across the health and social sectors. Most persons who have undergone sexual violence prefer the term “survivor” due to their having overcome the consequences associated with sexual violence. The term “survivor” also recognizes the agency of the survivor as one who has lived through the ordeal and continues to work towards the quality of life.

List of Acronyms and Abbreviations

ANC	Ante-Natal Care
CBO	Community-Based Organization
CDC	Centres for Disease Control
CHMT	County Health Management Team
COE	Chain of Evidence
CCC	Comprehensive Care Clinic
CUC	Court User Committees
EC	Emergency Contraceptives
GBV	Gender-Based Violence
GBVRC	Gender-Based Violence Recovery Centres
GoK	Government of Kenya
HCWs	Health Care Workers
HIV	Human Immuno-Deficiency Virus
IEC	Information, Education and Communication
IPV	Intimate Partner Violence
KDHS	Kenya Demographic Health Survey
KHIS	Kenya Health Information System
LMICs	Low and Middle-Income Countries
MoH	Ministry of Health
NGEC	National Gender and Equality Commission
NGO	Non-Governmental Organization
NACOSTI	National Commission for Science, Technology and Innovation

OB	Occurrence Book
OPD	Out-Patient Department
OOP	Out of Pocket
OSCs	One-Stop Centres
P3	Kenya Police Examination form
PEP	Post Exposure Prophylaxis
PRC	Post Rape Care
PTSD	Post-Traumatic Stress Disorder
RH	Reproductive Health
RHTWG	Reproductive Health Technical Working Group
QI	Quality Improvement
SGBV	Sexual Gender-Based Violence
SDP	Service Delivery Point
SOA	Sexual Offences Act
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
VAC	Violence Against Children
VAW	Violence Against Women
TFSOA	Taskforce on the Implementation of the Sexual Offences Act
WHO	World Health Organization

Chapter 1 INTRODUCTION AND THESIS OVERVIEW

1.1. Introduction

Sexual Violence has received global recognition as a complex issue that requires concerted efforts towards prevention and response. However, despite the complexities resulting from sexual violence, few interventions have been undertaken to highlight the key ingredients to a strengthened multi-sectoral response framework. This chapter, therefore, provides a background about study. Discussed in this section are the various terms used to define sexual violence globally, and the legal definition of various forms of sexual violence in Kenya. This section further highlights the focus areas under study and the relevance thereof towards a strengthened response to sexual violence.

Sexual violence is prevalent in all countries. Globally, sexual violence is a major global human right and a public health concern (Campbell, 2002, Heise et al., 2002, Krug et al., 2002, Dworkin et al., 2017). The occurrence of sexual violence is more prevalent in cultures where the male gender is regarded as superior based on the prevalent gender norms and socio-cultural practices (Kalra and Bhugra, 2013). Worth noting is that the constituents of sexual violence in countries differ, however, based on the cultural contexts and particularly the accepted definition of "coercion"- a critical component in the WHO definition of sexual violence (WHO,2002).

In Kenya, despite the existence of a Sexual Offences Act (Government of Kenya, 2006) and Guidelines for management of survivors of sexual violence that involves multi-sector stakeholders (Government of Kenya, 2012; Ministry of Health, 2016), described below, there is little evidence on the functionality of this multipronged approach as it currently exists. Key to the success of the sexual violence chain of evidence and custody is the capacity of service

providers; the implementation of Standard Operating Procedures (SOPs); the implementation of an effective package of services, appropriate referral of survivors and action taken by the criminal justice system. The study will contribute to filling gaps in this evidence.

According to the World Health Organization, sexual violence refers to, "any sexual act or an attempt to obtain a sexual act, unwanted sexual comments, or advances, acts to traffic or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim in any setting, including but not limited to home and work" (World Health Organization, 2002). According to Section 3 (Ranney et al., 2011b) of the Kenyan Sexual Offences Act no 3 of 2016 (hereafter referred to as the Act), sexual violence is defined as when (a) a person intentionally and unlawfully commits an act which causes penetration with his or her genital organs; (b) the other person does not consent to the penetration; or (c) the consent is obtained by force or using threats or intimidation of any kind (Government of Kenya, 2006). Section 42 of the Act provides that "a person consents if he or she agrees by choice and has the freedom and capacity to make that choice" (Government of Kenya, 2006b p. 27). In Kenya, the following types of sexual violence are included in the Act: rape, defilement, gang rape, sexual assault, sexual harassment, deliberate infection with HIV, child trafficking for sexual exploitation, and child pornography (*Appendix 1 provides a full description of the types of sexual violence as defined within the Kenya Sexual Offences Act*). This thesis focusses on two forms of sexual violence: rape and defilement.

Rape refers to an act of forced or coerced oral, anal, or vaginal penetration of someone aged 18 years and above. It occurs to both men and women (Weiss, 2010; Dartnall and Jewkes, 2013; LeMaire et al., 2016). In Kenya, the Sexual Offences Act No. 3 of 2006

defines rape to have occurred when one intentionally and unlawfully commits an act which causes penetration with his/her genital organs without consent from the other person or when consent is obtained through by force or using threats or intimidation of any kind (Government of Kenya). Rape is also deemed to occur when the penetration on one's genitalia is done by use of an object. According to the Act, rape can be committed by either males or females. This is contrary to community perceptions that also relate to the Penal code[1] where it is assumed that its only male persons who could commit rape by virtue of their ability to penetrate. It is also contrary to the reported cases in hospitals and police records of males having been coerced into sexual acts by females or males.

Defilement is a term used according to the Kenya Sexual Offences Act No. 3 of 2006 refers to an act of sexual penetration or rape with a child (In Kenya, a child is a person below 18 years). While consent is a key component of the sexual offences Act, it is considered immaterial in the case of defilement in Kenya. According to the Sexual Offences Act (TFSOA, 2013), any sexual encounter with a child is deemed to be a sexual violation given that the legal age of consent in Kenya is 18 years. Scholars have applied different terms to discuss coerced and non-consensual sexual contact between individuals, such as sexual abuse, sexual offences, Sexual and Gender-Based Violence (SGBV) and sexual assault (Omanyondo, 2005; DeGue and DeLillo, 2005; Greathouse et al.,2015). However, the underlying meaning of these various nuances remains the same. This study would also like to recognize that most data on violence captures the other forms of Gender-Based Violence (GBV), namely physical, emotional, and economic. In this study, sexual violence, therefore, entails completed or

[1] Section 139 of the Penal Code: "Any person who has unlawful carnal knowledge of a woman or girl, without her consent, or with her consent if the consent is obtained by force or by means of threats or intimidation of any kind, or by fear of bodily harm, or by means of false representation as to the nature of the act, or in the case of a married woman, by personating her husband, is guilty of the felony termed rape".

attempted forced sexual contact regardless of the number of perpetrators and age of survivor.

Although the Sexual Offences Act of 2006 clearly outlines what constitutes the different forms of sexual violence, there exist limitations with regards to the community understanding and perception of what constitutes a sexual violation. In certain communities in Kenya, incest is regarded more as a cultural taboo as opposed to a criminal offence. In addition, the customary law permits certain practices which in the spirit of the Act are classified as rape. For example, in certain communities in Kenya, forceful sex with a widow by her in-laws is permitted as an act of cleansing. A widow who declines to undergo this ritual is often disinherited and alienated from the family. This conflict between customary and civil laws contributes to the gaps in reporting of such cases when they occur due to fear of conflict between legal jurisprudence and cultural ethos. Worth mentioning is that the definitions of various forms of sexual violence do not also align to the categories of the forms of violence listed in the Kenya medico-legal form (also known as the Post Rape Care form 363). According to the PRC form 363, the types of sexual violence are captured based on the body part where the penetration occurred. That is, the "types" of sexual violence listed on the PRC form include: anal, vaginal, and oral as illustrated in Figure 1 below.

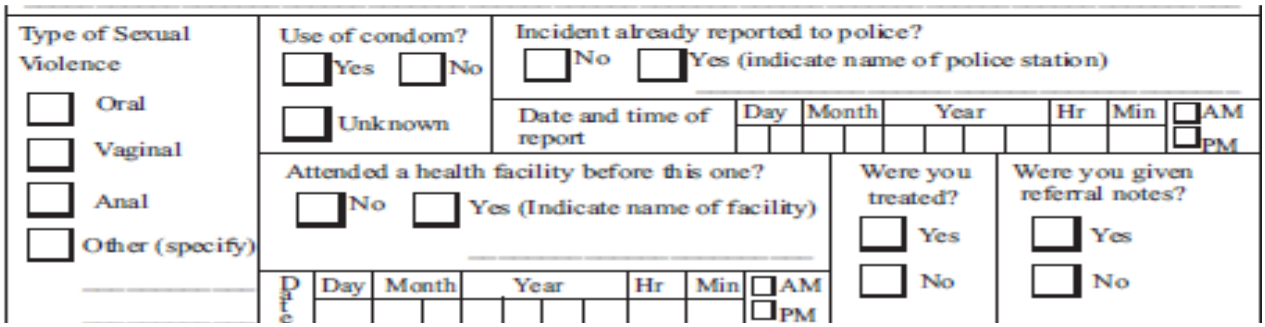


Figure 1: Types of sexual violence as stipulated on the PRC form

The disconnect in terminologies stipulated within the sexual offences Act and the medico-legal data capture tools presents a challenge in the responses made by different sectors towards addressing cases reported. It also complicates the referral of survivors from one sector to the other due to different terms used to describe the case reported by the survivor. This study recognized the multifaced nature of sexual violence that calls for a multi-sectoral engagement in the management of survivors (Keesbury and Askew, 2010).

Several efforts initiated globally by many stakeholders, including the World Health Organization, seek to address the need for a multi-pronged approach in addressing the impacts associated with sexual violence. These efforts revolve around the capacity building of service providers; development of standard operating procedures; monitoring and evaluation; legal aid, and referral to shelters (Colombini et al., 2008b, UNWOMEN, 2013, Sullivan, 2012, Bell and Goodman, 2001, Jewkes, 2014). The need for a multi-sectoral response is informed by the impact of sexual violence as it creates significant challenges to individuals in their efforts to receive medical, emotional, physical safety, and legal support (Colombini et al., 2008a). Globally, the recommended package of services for survivors of sexual violence focusses on the management of physical injuries, psychological trauma, prevention of unwanted pregnancies, HIV and other sexually transmitted infections, and collection of medical-legal evidence (WHO. and UNHCR, 2004, World Health Organization,

2003;2004). However, contextualized responses are required in an effort to align interventions to the existing policy frameworks. It is important to understand and recognize the existing links between the health sector, police and the community as a basis to address the complexities surrounding sexual violence (Du Mont et al., 2007). A review of the functionality of a multi-agency response to sexual violence in Britain showed that despite the existence of clearly defined roles for the different sectors, a disconnect still exists in service provision and coordination of the cases attended to by different sectors (Robinson et al., 2008). The review further showed that conflict in roles discharged by different players contributes to the delayed provision of a timely and quality response to survivors. This resonates with the Kenyan context where each sector has a defined mandate towards the response of sexual violence, thus resulting in delayed referral or survivors who first report to the police or vice versa. While the police are keen on ensuring proper evidence is collected and preserved, the health providers focus more on clinical management of the survivor due to the time specifications within which prophylaxis is to be administered. In addition, in Kenya, there is no ring-fenced budget to support a coordinated response to sexual violence. Thus present challenges in the implementation of a multi-sectoral intervention as stipulated in the national sexual violence multi-sectoral SOPs (TFSOA, 2013). Efforts have been made through Section 47 of the Sexual Offences Act to foster collaboration across various sectors (Charillus, 2017). However, In Kenya, there exists a need for strengthened mechanisms to enhance cross sectoral referrals as highlighted in a systematic review undertaken by the current Kenya current response mechanism. In the review, Muthoni (2019) calls for the setting up of a multiagency team at various levels to inform the development of harmonized capacity building approaches, common indicators, and collaborative approaches (Muthoni,

2019). This is further addressed through this thesis, with a focus on assessing the state of uptake of services across sectors.

In Kenya, the recommended management measures of responding to sexual violence include the clinical management of physical injuries arising from the abuse; provision of prophylaxis for prevention of HIV and pregnancy; a collection of forensic samples for medico-legal purposes; trauma counselling, and documentation and results on the laboratory investigation on the requisite national tools (Ministry of Health, 2016). The comprehensive response to sexual violence, therefore, calls for a coordinated engagement between different sectors. Consequently, the justice system in Kenya relies on the evidence obtained through the health sector to prosecute cases of sexual violence presented by the police. The underlying reason for this is that the health sector plays a critical role in collecting forensic evidence and detailed history from the survivors, which constitute an integral part of the judicial processes. The appropriate management of the survivors of sexual violence, therefore, requires a standardized clinical evaluation and an effective interface with law enforcement for the handling of forensic evidence (World Health Organization, 2004; Kilonzo et al., 2013; Keesbury and Askew, 2010; Ajema et al., 2011b). However, limited research has been conducted in Kenya to understand how the multi-sectoral response to sexual violence responds to the needs of survivors.

In Kenya, studies undertaken have sought to understand practices observed towards the medical management of survivors of sexual violence (Ajema et al., 2011b; Gatuguta et al.; 2018; Ranney et al., 2011b; Ajema et al., 2015). These studies show that survivors do not access comprehensive medical management due to delayed reporting, provider attitude, weak or delayed inter and intra-facility referrals for survivors (Ajema et al., 2015; Kilonzo et

al., 2008a, Kilonzo, 2003; Gatuguta et al., 2018; Wangamati, 2014). In addition, the studies demonstrate a limitation on data with regards to the functionality of the referrals mechanisms from other sectors; namely: police, child protection or rescue centers, and judiciary, to the health sector and vice versa. As a result, there is a need to understand survivor experiences in navigating across the health, legal, security and social sectors for treatment and support. It is also important to obtain insights into providers' experiences in referring survivors of sexual violence. Relatively few studies have been conducted globally and in Kenya on the linkages in the chain of evidence and custody in multi-sectoral reporting and referral mechanisms for survivors. This is an important gap that warrants further investigation.

Country policy frameworks in place highlight the need for multi-sectoral response mechanisms to sexual violence, given that the multiple needs of survivors cannot be met by a single institution. The health sector continues to play a key role in the prevention, care and rehabilitation following sexual violence. Access to comprehensive health care and justice, however, seems to be limited given the inadequate knowledge by the wider public on available services, as well as where and when they can access these services. This is due to undefined referral pathways (Ajema et al., 2008; Njuki et al., 2012; Crichton et al., 2008). As is in other countries (Duncan and Western, 2011), delivery of post rape care services in Kenya is often siloed (Kilonzo et al., 2009d), with limited focus on enhancing medico-legal linkages (Kilonzo et al., 2009a). No study has been undertaken in Kenya to establish the functionality of the multi-sectoral referral pathways stipulated within the existing policy frameworks.

This thesis reviews and analyses multi-sectoral responses to sexual violence which could help inform interventions to enhance the coordinated multi-pronged approach to

reporting and referral of cases of sexual violence in Kenya and other developing countries. This study sought to understand the role of the health, security, legal and social sectors in managing survivors of sexual violence in Kenya. Additionally, this study aimed at highlighting the health sector service delivery package and how this affects the referral of survivors for both clinical and non-clinical based services. Thus, this study was conceptualized within a multi-faceted approach by focusing on the health, police, judiciary and community aspects. This study aims to understand service experiences and provision and investigate the functionality of the existing multi-stakeholder management of sexual violence survivors in Kenya. The objectives of this study were as follows:

i. To establish the characteristics of reporting rape survivors and current practices used by different sectors in managing survivors of sexual violence and reporting systems. This was achieved through a review of data at the hospitals, police stations and courts; in addition to interviews with providers and survivors (including caregivers)
ii. To explore survivor experiences (and perceptions) in accessing Post Rape Care (PRC) services from across different sectors
iii. To determine current status and gaps of post rape care coordination and networking mechanisms across sectors. This was done through a review of the data maintained for survivors across different service points. In addition, interviews with providers were also utilized to show gaps in current sectoral coordination efforts.

1.2. Structure of the thesis

The thesis follows a logical sequence as outlined below:

Chapter 1: Provides an introduction, objectives, and an overview of the thesis.

Chapter 2: Highlights the magnitude of sexual violence as presented in international and national literature. This chapter presents current responses--global and national--in addressing sexual violence and the gaps hitherto. It also includes an overview of the definition of sexual violence within the Kenyan legal framework, current service delivery mechanisms, and a conceptual framework underpinning this dissertation.

Chapter 3: Explains the study methodology. It provides a rationale for the methods that were utilised, both qualitative and quantitative. This chapter further shows, a detailed approach to the type of and how data were collected, how respondents were recruited, and how data was managed and analysed.

Chapter 4 and 5: Discusses in detail, the main findings generated from this study which encompasses is findings from participant interviews, and a review of records maintained for survivors at the health facilities, police stations and courts. The findings are presented in two different sections, for the qualitative and quantitative data, respectively.

Chapter 6: Argues the implications of study findings. This chapter also outlines the contribution that this thesis has made to the existing body of knowledge on multi-sectoral response to sexual violence. It also gives recommendations for future areas of research and policy engagement. Finally, the chapter draws a conclusion on the topic under study.

Chapter 2 LITERATURE REVIEW

2.1. Introduction

In this chapter, I examine the magnitude and effects of sexual violence. Response mechanisms are discussed, and pertinent literature reviewed. This literature review comprises a review of the existing evidence on the multi-sectoral response to sexual violence from a National and a global perspective. The chapter presents an overview of the Kenyan definitions of sexual violence and the consequences associated with sexual violence as presented in global and national literature. Also addressed are the current Kenyan practices, including patient flow and referrals, data capture and reporting systems utilized by different sectors to manage survivors of sexual violence. This chapter further highlights the previous research on the post-sexual violence service delivery models, experiences of survivors in accessing Post Rape Care services as well as the gaps in coordinating post rape care across different sectors.

2.2. Global perspectives on the prevalence and impact of sexual violence

Globally, sexual violence remains both a public health problem (Dahlberg and Mercy, 2009; Abramsky et al., 2011) and a human rights concern (Krug et al., 2002; Jewkes, 2002). The WHO Global estimates indicate that about one in three women worldwide has experienced sexual violence in their lifetime (WHO, 2013; Hall et al., 2014). Prevalence of sexual violence as reported from population-based studies vary by region and range between 6 per cent and 59 per cent (Garcia-Moreno et al., 2006; Devries et al., 2013; WHO, 2013, 2014). Existing literature demonstrates that 5 per cent to 15 per cent of females in Africa experience sexual abuse (Daru et al., 2011). Further studies undertaken by Center for Disease Control (CDC) in four African countries revealed varied prevalence rates of 15 per cent in

Zambia, 28 per cent Uganda, 29 per cent Nigeria and 51 per cent in Malawi (Swedo et al., 2019). However, past studies carried out in Sub - Saharan Africa indicate a high prevalence rate of 65 per cent (WHO, 2013). In Mozambique, 31% of women report having experienced sexual violence in their lifetime (Cruz et al., 2014). Further studies undertaken in Namibia, Tanzania and Nigeria have revealed a prevalence rate of between 16 per cent and 59 per cent; figures that resonate with other Sub Saharan counties despite slight variations in the rates (Kilonzo et al., 2009a). Evidence indicates that more than half of children aged between two and 17 years in 96 countries have experienced some form of violence (Hillis et al., 2016). Girls are more susceptible to sexual violence than boys. Globally, about one in 10 girls are reported to have experienced sexual violence (UNICEF, 2014b). Boys also report experiences of sexual violence, but to a lesser degree than girls in both high and low- income countries (Stoltenborgh et al., 2011). However, the stigma associated with male violence persists in many contexts. Hence, existing evidence highlights under-reporting of cases of male sexual violence, due to stigma, either due to the negative provider attitudes or fear of reprisal or ridicule from community members. A study conducted in the UK revealed a male to female sexual violence reporting ratio of 1:2 cases (Weiss, 2010). However, these statistics in most countries are based on population surveys and not focused specifically on sexual violence thus may be less than accurate.

According to the Kenya Demographic Health Survey (KDHS, 2014), 41 per cent and 11 per cent of ever-married women and men, respectively, aged between 15 and 49 years have experienced either physical or sexual violence committed by their spouse/partner. The Violence against Children Survey indicated that one in 10 girls (10.7 per cent) and one in 20 boys (4.2 per cent) had experienced at least one episode of sexual violence in the previous 12

months (UNICEF, 2012). The survey also revealed that 32 per cent of females and 18 per cent of males had experienced sexual violence before they had reached 18 years of age (UNICEF, 2012). Studies that were undertaken in Kenya public health facilities indicate that majority of survivors reporting for post-rape care services in health facilities are aged below 18 years (Ranney et al., 2011a; Wangamati, 2014; Wangamati et al., 2017a). According to the Kenya Annual Crime report (2018), there has been a notable increase in cases of sexual violence reported in the Country. A total of 7233 cases were reported in 2018 compared to 5492 cases reported in 2017. Fourteen per cent (14 %) of the reported cases were of rape, and 77 per cent of defilement, (used in Kenya to define rape of a minor (< 18 years), and the rest of unnatural offences, indecent acts and bestiality (NPS, 2019).

However, there are challenges to establishing the accurate estimates of sexual violence, including under-reporting, variances in the definition of forms of sexual violence across regions, lack of data capture tools to adequately capture cases reported across sectors and regions, and methodological issues in various research studies (Hillis et al., 2016; Stoltenborgh et al., 2011). For instance, in certain contexts, studies have relied on self-reports by community members of their past experiences of GBV, or retrospective data collection to establish those who have even been violated during childhood. These methodological issues also flag up issues surrounding recall bias. In most countries, the sexual violence estimates are often derived from routine service statistics in data collected from cases reported in health facilities, police and/or courts. These reports may be biased due to under-reporting as a result of the stigma associated with sexual violence in many cultural contexts (Patel, 2011). This is congruent with data obtained through a study in Tanzania where non-reporting of cases of sexual violence was linked to the fact that the

perpetrator was someone well known to the survivor (Cruz et al., 2014). The data collected may also not have been recorded accurately.

Sexual violence significantly affects the physical, sexual, reproductive, emotional, mental and social well-being of individuals and their families (Josse, 2010, Antai, 2011, Peltzer et al., 2013). Survivors of sexual violence are exposed to adverse reproductive outcomes and an increased risk of short and long term health-related complications such as increased risks of unintended pregnancies (Ikamari et al., 2013; Stephenson et al.,2016), sexually transmitted diseases including HIV (Dude, 2011; Mmbaga et al., 2007), and mental health problems such as Post-Stress Traumatic Disorders (Ansara and Hindin, 2011; Avdibegović and Sinanović, 2006; Pico-Alfonso et al., 2006; Bebbington et al., 2011; Devries et al., 2011). Sexual violence also impacts on an individual psychologically or emotionally due to stigma, abandonment and discrimination meted on them by their social networks (Deb and Walsh, 2012; Wangamati et al., 2016). The impact of sexual violence differs in each survivor due to their individual uniqueness and the variation in the sexual assault characteristics. Consequently, the degree and severity of the health outcomes vary, ranging from minor to life-threatening, immediate to chronic (Jina and Thomas, 2013; Buckingham and Daniolos, 2013). Existing evidence links some of these adverse effects to self-stigmatization, and the adaption of harmful behavior such as substance abuse (García-Moreno et al., 2015)

I expound further below the association between sexual violence and the adverse outcomes mentioned above.

Sexual and reproductive health-related outcomes: Some studies have shown that women with experiences of sexual violence are least likely to use contraception (Kaneda and

Smith, 2015; Pallitto and O'Campo; 2004; Stephenson et al., 2008). Some of the reasons highlighted in past studies include the association of contraceptive use with promiscuity, as well as women lacking the autonomy to make decisions regarding their reproductive health, to name but a few. Pregnancy-related outcomes have far-reaching long-term psychosocial consequences to survivors. In the United States, for instance, approximately 2.9 million women have experienced a rape-related pregnancy (Basile et al., 2018). The outcomes of such pregnancies vary with some studies documenting that as many as half of these pregnancies end in elective abortion (Silverman et al., 2007; Alio et al., 2009; Stöckl et al., 2012). Others experience spontaneous abortion, while some survivors opt to give up their children for adoption (Bruyn, 2003; McFarlane et al., 2005). Similarly, a study in Ontario, Canada showed that women with a history of sexual abuse had two times the odds of repeat-induced abortions (Fisher et al. 2005). Additionally, in a multi-country study by WHO, an analysis of data from 17,518 women from 10 countries indicated that women with a history of intimate partner violence had significantly higher odds of unintended pregnancies and abortion (Pallito 2013). In most countries, particularly in Africa, pregnancies arising from incestuous relationships are regarded a taboo, and in some as a curse (Ramakuela et al., 2016), thus more likely resulting in termination of the pregnancies. Sometimes there is ex-communication of the survivor or perpetrator, and/or placement of the infant for adoption.

Mental health outcomes and sexual violence: Survivors of sexual violence experience complex mental health problems. The typical symptoms following rape are recognized in the Rape Trauma Syndrome (RTS), first described by Burgess and Holmstrom in 1974 (Burgess and Holmstrom, 1974). The wide array of psychological and emotional problems associated with sexual violence include depression (Bebbington et al., 2011), sexual dysfunction, sleep

disorders, eating disorders, substance abuse, behavioral problems (Jayne and Valentine, 2016, Chen et al., 2010), suicidal ideation (Devries et al., 2011), Post-Stress Traumatic Disorder (PTSD) (Wuest et al., 2007; Chandra et al., 2009; Kmett Danielson et al., 2010; Campbell et al., 2009), anxiety (Salehi Fadardi, 2009), and suicidal tendencies (Ellsberg et al., 2008; Eshelman and Levendosky, 2012; Dillon et al., 2013). For instance, 6 per cent of adolescent girls in Ethiopia and 15 per cent in Canada who had experienced sexual violence were reported to have attempted to commit suicide (Krug et al., 2002). The majority (>90%) of survivors of sexual violence report symptoms consistent with PTSD with some starting immediately after the violation and persisting for many years after the incident (Jaycox et al., 2002). Survivors with PSTD tend to be more suicidal (Shamu et al., 2016; Mondin et al., 2016). The negative mental outcomes are often linked to community reactions to sexual violence which often result in the survivor being blamed for the incident. Some of the mental health outcomes discussed above could be either associated with a lack of psychosocial support or the stigma associated with uptake of counselling services at the community level. A study conducted in the Democratic Republic of Congo revealed that limited uptake of medical services is linked to incidences where survivors who sought services were evicted from their homes and considered to be a bad omen to the community (Kelly et al., 2012).

Injuries associated with sexual violence: Sexual violence also results in injuries to many survivors (Chivers-Wilson, 2006). Physical injuries could be as a result of physical assault inflicted on any part of the body or as a result of forceful penetration resulting in injuries in the genital tract or anus (Sheridan and Nash, 2007; Merritt, 2008). The injuries often accrue from the survivors being kicked, shoved, slapped, pushed, burnt, scalded, harmed with an object, or coerced to have sexual intercourse. Globally, there is evidence of

the existing association between sexual violence, bodily harm and genital injuries (Maguire et al., 2009; Zilkens et al., 2017a; McLean et al., 2011). Some of the manifestations of injuries include bruises - mostly located on the face and limbs, abrasions, lacerations, burns and amputation (Alempijevic et al., 2007). Worth noting is that not all cases of sexual violence result in physical injuries due to the nature of the relationship between the perpetrator and the survivor, the age of the survivor, the nature of the sexual assault, and object(s) used during the incident (Zilkens et al., 2017b). Nevertheless, injuries from sexual violence result in long term effects, especially those in bodily harm or irreparable anogenital injuries. Evidence demonstrates high levels of stigma associated with sexual violence-related injuries such as women who suffer from fistula (Onsrud et al., 2008; Dossa et al., 2014). These women are often ostracized by their families and society at large (Longombe et al., 2008). In Kenya, existing response mechanisms have tried to put in place measures to address resulting injuries. However, a gap exists in managing survivors who may not openly disclose to a health provider that the injury is linked to an incident related to sexual violence.

Severe forms of physical injury have been demonstrated in humanitarian contexts where women are raped including during post-election violence in Kenya, and wars in Northern Uganda and Congo (Liebling et al., 2008; Anastario et al. 2014). In the Congo, women reported traumatic gynecological fistulae and genital injury from brutal sexual violence and gang rape (Ahuka 2008). A review of medical records from 1615 cases of sexual violence reported during the post-election violence in Kenya, revealed a delayed reporting of cases of sexual violence for up to one month despite the injuries resulting from the abuse (Anastario et al. 2014). Some of the reasons for the delayed reporting include barriers to access to the facility due to lack of knowledge regarding immediate access to a health facility,

cost-related barriers to accessing health facilities and competing interests to meeting a basic need (Anastario et al. 2014). Reported delays in seeking and obtaining services highlight the need for a multi-sectoral approach in order to ensure the survivors receive prompt care.

Social and economic costs: There are social and economic costs associated with sexual violence (Fearon and Hoeffler, 2014; Raghavendra et al., 2017; Peterson et al., 2018). These costs occur at multiple levels: individual, community and government (Ellery et al., 2010) and they are often grouped into two: direct and indirect costs. Direct cost refers to the Out-Of-Pocket (OOP) expenses incurred in seeking care and support from hospitals (Jones et al., 2006), police stations, judiciary and protection agencies (United Nations, 2005). Indirect costs include the value attached to benefits or services a survivor loses for example income, costs attached to morbidity, reduced productivity through absenteeism or mental trauma, pain, suffering and death arising from the violation, adoption of risky coping behaviors such as engaging in drug and substance abuse (Duvvury et al., 2012). However, health care costs account for a significant proportion of costs incurred by most survivors across the globe (Rivara et al., 2007; Bonomi et al., 2009). The sexual violence-related medical costs include costs of treatment, transport costs to and from the health facilities and referrals for long term care, including physiotherapy and counselling. A population-based survey undertaken in the USA estimated that the direct costs of responding to sexual violence to be at $265 million in the USA (Yang et al., 2014). Global evidence approximates the cost of broader Violence Against Women (VAW) (which includes sexual violence) to about USD$4 trillion (Fearon and Hoeffler, 2014). The costs of violence relative to the Gross Domestic Product (GDP) in developing countries range between 1.41 per cent to 3.7 per cent (Ashe et al., 2016). In Kenya, the National Gender and Equality Commission (NGEC) approximates the

health-related costs to survivors to be USD 165 per incident, USD 530 towards litigation fees and $ 850 in court-related fines per case (NGEC, 2016). These costs exclude those related to travel and time in moving from one point of care to the other. In Kenya, for example, the post-sexual violence services are located in different areas which require survivors to travel across different institutions. This not only incurs a cost element but also emotionally draining as one is required to narrate their story at each point.

The social costs arise from survivors (or their caregivers) missing out on their livelihood due to poor health and social outcomes, and relocation of residences to reduce victimization or threats from the perpetrator (Fearon and Hoeffler, 2014; Ward and Marsh, 2006). Sexual violence in most countries, including Kenya, is regarded as a criminal offence (Government of Kenya, 2006b). Consequently, survivors who choose to pursue legal redress often incur personal costs from reporting to the legal determination of the complaint presented within the judicial system (Braun, 2014). The legal costs accrue from the heavy burden of responsibility that is placed on the survivor to not only report a violation but persevere through the time consuming and emotionally draining judicial processes which contribute to further monetary and social costs. In Kenya, lengthy judicial processes also weigh heavily on the financial status of the survivors and their families (National Crime Victim Law Institute, 2005). This is contrary to the provisions of the Victims Protection Act No.17 of 2014 which seeks to (a) " recognize and give effect to the rights of victims of crime; (b) protect the dignity of victims (these include survivors of sexual violence), and promote co-operation between all government departments and other organizations and agencies involved in working with victims of crime." The Act also stipulates that it's the right of every victim to be accorded legal and social services at the State's expense. This situation is not

unique to Kenya. Evidence from Sub-Saharan Africa also highlights the social costs linked to sexual violence often backed up by customary law. For example, according to the customary laws in Kenya, cases of incest and marital rape though recognized in jurisprudence, ought to be settled by clan elders as they are considered more of a violation of culture than the existing laws. Customary arbitration of cases allows for the survivors and their families to receive compensation from the perpetrators as opposed to bringing shame to the family by reporting to the police (Freccero et al., 2011).

2.3. Reporting and referral of cases of sexual violence

The survivor resilience of post-assault is dependent on the strength of their support systems (WHO, 2017). Management of sexual violence requires the involvement of survivors both in terms of timely reporting of the case and service providers. Service providers play an important role in the identification, management and referral of survivors for the required comprehensive care. Evidence confirms that despite the impact on survivors of sexual violence, there are some survivors who fail to report sexual violence and do not receive medico-legal care (Carretta et al., 2015). Some of the reasons for failed reporting of sexual violence include lack of knowledge of where to report, self-blame for the incident (Heath et al., 2011), fear of not being believed (Ahrens et al., 2007; Sable et al., 2006), lack of understanding on whether the incident amounts to sexual violence, especially when committed by an intimate partner and/or close acquaintance (Koo et al., 2015). Delayed and under-reporting of cases of sexual violence is an issue of concern in most countries (Saidi et al., 2008). A study conducted in the Democratic Republic of Congo among 255 women, showed that approximately 45 per cent of the women sought help more than 365 days after the assault, and only 4 per cent received the emergency care package for having reported

within 72 hours. In addition, the same study highlighted that distance to facilities poses a barrier to access with fifty-five per cent of the women reported having taken more than one travel day to access services (Kelly et al., 2011; Kohli et al., 2012). A population-based study conducted in Sweden on the extent of reporting sexual violence cases revealed that only 5 per cent to 10 per cent of women who had experienced sexual violence sought professional help (HÄLSA, 2014). Self-victimization thus resulting in the adoption of an avoidance behavior also contributes to lack of help-seeking on the part of some of the survivors of sexual violence (Leiner et al., 2012; Pineles et al., 2011). A capacity assessment of the referral mechanisms in place in South Africa's rape specialists' centers revealed the existence of a defined referral protocol in place that entailed the issue of a standard letter to the survivors of sexual violence for onward submission to the referral point. However, the standard was not applied as required. In some instances, providers did not give referral information to survivors for fear of overwhelming the survivors with information during the initial visit, while others expected the survivors to initiate appointments on their own (Gevers et al., 2015). In Kenya, no study has been undertaken to establish the operationalization of the multi-sectoral referral of survivors, as stipulated in the national policies on the management of sexual violence cases. It is unclear whether all providers across different sectors are cognizant of the importance of a coordinated referral mechanism and how to make the system efficient and sensitive to the needs of the survivors.

For survivors who seek care, the World Health Organization (WHO) recognizes the presence of limited evidence on the functionality of the referral and follow up of cases of sexual violence reported in different sectors across many countries (World Health Organization, 2013). Globally, it is documented that survivors of sexual violence can either

report to “formal” or “informal” system for support (Levy et al., 2016). Formal structures are those institutions defined within the government-sanctioned legal and policy frameworks to have a key role in addressing sexual violence (Such as police, health, and children's department), while informal structures mostly operate at the community level and vary from region to region (for example village administration, religious leaders, clan system,). Other informal support often entails disclosing the incident to friends, relatives or religious leaders (Sabina and Ho, 2014). There is limited evidence on how survivors navigate the different systems to receive care (Gevers et al., 2015). There is a lack of defined reporting and linkage between the formal and informal systems of care in Kenya.

It is worth noting that reporting to either formal or non-formal system does not guarantee the survivor of the required help. A New Zealand study undertaken from a general population of 965 women revealed that while 75% of them disclosed the violence to someone, only 40% of them got the support they required (Fanslow and Robinson, 2010). In the same study, not all women who reported to either the police or hospital were adequately attended to. This is congruent with a study conducted in the USA which revealed that survivors opted to report to either formal or informal networks, with 24 per cent reporting to one formal provider. The same population reported having received negative reactions from providers upon disclosure (Jacques-Tiura et al., 2010). This is similar to the Kenyan context, where survivors do not necessarily get adequately supported when they report to either formal or informal sources. For instance, a study conducted in an informal settlement in Kenya indicated that 25% per cent of cases were not reported due to fear and in some instances, fear of retaliation (Syombua, 2014). In some cases, survivors or their caregivers opt to report their case to a local chief since the pathways of support are not clearly defined.

Ideally, local administrations are required to refer all sexual violence cases reported to them either to the police or hospital depending on their proximity. In most cases involving sexual violence in marriage, the offences are resolved through informal networks in accordance with the customary law. Kenya customary law subjugates women as a property belonging to their husbands. Consequently, any conflict arising from such unions (including those that border on sex) is to be determined by clan elders or the local administrators who are often men. The reporting of cases of sexual violence to informal networks is contrary to the provisions of the national sexual violence guidelines and against the SOA, and children's Act. The National Guidelines indicate that once the incidence occurs, it should be reported to either the police or hospital. Therefore, sexual violence is a cross-cutting issue which requires a multi-sectoral approach from reporting the issue to its the effective management of the issue.

Available research highlights the need for a further investigation of gaps in referral mechanisms for survivors. This is best highlighted by a qualitative study of20 families in South Africa in which caregivers reported lack of knowledge of the available treatment and/or challenges in taking up referrals due to costs involved or poorly coordinated referrals and follow up sessions (Williamson et al., 2017). The same study revealed the need for referral to psychological interventions. Further, a study undertaken in Gulu District in Uganda revealed a reluctance by some providers to fill the medical forms owing to fear of their being summoned in court (Henttonen et al., 2008). The same study conducted in Uganda revealed that only one in eight facilities assessed utilized national PRC data capture tools and service delivery protocols thus resulting in discrepancies in the drug regimen issued to survivors (Henttonen

et al., 2008). Further, studies globally show that provision of poor-quality services is a deterrent to health-seeking by survivors (Martin et al., 2007, Smith et al., 2013).

2.4. A comprehensive multi-sectoral response framework to sexual violence in Sub-Saharan Africa

Significant investments have been made by the WHO (WHO, 2013; 2014;2017) and most countries to address the health-related outcomes associated with sexual violence (UNWOMEN, 2013; García-Moreno et al., 2015; UNFPA, 2010). The multifaceted consequences of GBV have resulted in increased global recognition for the need for multi-sectoral sexual violence response mechanisms (UN Women, 2013). A comprehensive system allows for the delivery of a full range of services and promotes effective linkages across institutions involved in the management of survivors (Keesbury and Askew, 2010). According to the WHO, the services that should be offered to survivors include the provision of prophylaxis, physical examination, retrieval of evidence, management of injuries, psychosocial support, referral for non-medical care and documentation of services offered (World Health Organization, 2003). A similar package of care is offered in most Sub-Saharan Counties, such as Zimbabwe (Sithole et al., 2018). In Kenya, the core components of a comprehensive response to sexual violence include clinical evaluation, examination and documentation to ensure the survivor receives the correct management of results of the investigations undertaken and that these results are well documented. These are: Clinical care which entails HIV testing, HIV prevention through the use of Post Exposure Prophylaxis (PEP), pregnancy prevention through the provision of emergency contraception (EC), STI management; Psychosocial support of survivors to address their mental health needs through counselling for trauma; and linkages and referral for further medical, social and/or legal aid for survivors (Ministry of Health, 2016). Survivors are to be initiated to HIV PEP as soon as

possible and within three days - 72 hours (Speight et al., 2006); while the non-pregnant female survivors(upon a confirmatory negative pregnancy test) and those not on any contraceptive method are, to receive emergency contraceptives within five days - 120 hours post assault (Ministry of Health, 2016; Muia et al., 2000). However, a different Post Rape Care (PRC) package is outlined based on the level of the facility in the country, as illustrated in Table 1 below.

Table 1: Minimum Standards for Providing Comprehensive PRC in Health Facilities[2]

	Minimum Standards for Medical management of survivors	Reporting/recording requirements for health facilities	Minimum capacity requirements at health facilities
All health facilities without a laboratory (public and private)	• Manage injuries as much as possible • Detailed history, examination and documentation (refer for HVS, PEP/EC, STI)	• Fill in PRC form in triplicate • Maintain PRC register • Please ensure that the survivor has a copy of the PRC form and takes it to the laboratory	• A trained nurse
All health facilities with a functioning laboratory (public and private)	• Manage injuries as much as possible • Detailed history, examination and documentation (including HVS) • Ideally, 1st doses of PEP/ EC should be provided (even where follow up management is not possible) • Where HIV Testing and Counselling (HTC) services are available, provide initial counselling	• Fill in PRC form in triplicate • Maintain a PRC register • Maintain a laboratory register • Referral to comprehensive post rape care facility	• A trained nurse and/or a clinical officer • A trained counsellor (where counselling is offered)
All health facilities with HIV, ARV or a Comprehensive Care Clinic (CCC) where Antiretrovirals (ARV) can be monitored (comprehensive post rape care facilities can be provided) (private and public health facilities)	• Manage injuries as much as possible • Detailed history, examination and documentation • Provide emergency and ongoing management of PEP • Provide EC • Provide STI prophylaxis or management • Provide counselling for trauma, HIV testing and PEP adherence	• Fill in PRC form in triplicate • Maintain PRC register • Maintain a laboratory register • Fill in PRC form to follow up management of survivors	• One medical or clinical officer trained in ARV/ PEP management • One trained counsellor (trauma, HIV testing and PEP adherence counselling) • Laboratory for HIV and HB testing • Preservation of sperms from HVS specimen

[2] Obtained from the Ministry of Health Kenya national guidelines on the management of sexual violence (2014)

Evidence shows that the multi-faceted effects of sexual violence cannot be adequately addressed through a single sector. Hence the need for collaboration and coordination across various sectors - health, social services, legal and security sectors (Ward and Marsh, 2006, Kilonzo et al., 2013; UNICEF, 2003). This is because survivors of sexual violence require services from each of these at various given times (Undie et al., 2012).

2.5. Effectiveness of the sexual violence service delivery models

Different service delivery models have been tested globally towards a strengthened sexual violence response (Keesbury et al., 2012). These include one-stop center service delivery models in South Africa, 'Thuthuzela centers' located in public hospitals, where medico-legal services are provided within a centralized location (UNICEF, 2009), Rwanda's Isange one-stop center located within the Kigali Police hospital where psychosocial, medical, police and legal services are offered to survivors of sexual violence (Cousins, 2019), Mozambique one-stop models where clinical services are offered alongside police, legal, and psychosocial support services in public health facilities (Gennari et al., 2016). One-stop centers also exist in Malawi, Malaysia, Namibia and Bangladesh (Colombini et al., 2008b). An evaluation conducted in Malawi of the existing one-stop centers revealed no initial significant association between increased client satisfaction--with services received including health, social welfare, police or counselling and--judicial case outcomes including arrests, or conviction of the perpetrators after the introduction of the one-stop service (Mulambia et al., 2018). In a qualitative study conducted in Malaysia on the functionality of a coordinated One-Stop Centres (OSCs) response to sexual violence, it was established that the success of this model is dependent on well-structured service provision infrastructure, trained personnel and effective implementation of policies (Colombini et al., 2012). The study further revealed

the limited financing attached to the functionality of the OSCs as a barrier to service provision, especially in instances where sexual violence is not a priority in most facilities in comparison to other health issues, such as HIV (Colombini et al., 2012). It was established that the OSCs did not guarantee the provision of care to survivors due to reasons that include non-prioritization of sexual violence. There were gaps in data capture, service provision and the multiple roles expected of staff who needed to provide services in other departments as well as for sexual violence in OSCs. There were also staff shortages, especially in lower-level facilities with few specialists, which in turn presented challenges in inter-departmental referral and coordination (Colombini et al., 2012). This study points out that while the OSC model is ideal for a coordinated response to sexual violence, its operationalization is pegged on buy-in from the hospital administrators to ensure sufficient allocation of resources for service provision. In Tulsa, Oklahoma, the proposed OSC model of care recommends that the OSCs are located in close proximity to the emergency department in order to enhance coordinated response while maximizing the available staff in the emergency department. The emergency departments operate 24 hours a day, have adequate and diverse skilled providers and sufficient budgetary allocations (Littel, 2001). However, there is a need for further analysis of the effectiveness and satisfaction of one-stop models.

The second model known internationally is one where services are integrated within different departments within a public health facility. The integrated service delivery points also attend to patients presenting with non-sexual violence-related health concerns, and they are closer to the majority of the populace in comparison to the one-stop models in order to maximize the scarce resources and reduce on attrition of survivors from care (Kelly and Reagan, 2003). The services offered include health, legal, welfare and counselling services in

one location. The integrated model is the most commonly used approach in Sub Saharan Africa in which most GBV medical and counselling services are offered in health facilities, and survivors are referred to the police thereafter (Chingumbe, 2018). The same model is being utilized in Zambia with the exception that in that Country, the emergency contraceptives are dispensed by the police before survivors are referred to the health facility (Keesbury et al., 2012; Undie et al., 2012). In Mozambique, the Post- GBV care centers are either stand-alone or are located within police stations (Gennari et al., 2016). However, both models call for a strengthened referral of survivors for comprehensive care, support for specialized health care and legal aid (Colombini et al., 2008b). A systematic review of the health sector response to sexual violence undertaken revealed the need for context-specific models of services delivery based on available resources and provider competencies (García-Moreno et al., 2015).

In Kenya, varied service delivery models are presently being utilized to deliver post rape care services (Kilonzo et al., 2009c). These include one-stop gender-based violence recovery centers where clinical, counselling and paralegal services are centralized in one geographical location within a health facility. Services in the recovery centers are offered by providers drawn multi-sectorally from the health sector, police and judiciary (Temmerman et al., 2019). However, only three such centers exist in the whole country due to the high personnel and infrastructural requirements required to set up such facilities. Under the integrated model, clinical and forensic post rape care and counselling services are offered from different service delivery points in both public and selected private facilities. Referrals are thereafter made to the police for further judicial follow up. In comparison to Mozambique and South African integrated models, where the referral pathways across

departments are well defined, in Kenya, the intra-facility referral differs per facility based on the outlay of the department and their location within the facility. A comprehensive response to sexual violence is, therefore, lacking in Kenya, and there are consequently calls for research to be conducted to establish whether these are well-defined referral pathways of reporting and evidence collection for survivors. Whereas there are defined Guidelines governing the response to sexual violence, there is limited research that has been undertaken in Kenya drawn from data generated from different sectors assessing the state of referral of survivors. In addition, this study also sought to bring to fore the gaps in current Kenya model that could help inform a coordinated response.

2.6. Documentation and chain of custody of sexual violence data in Kenya

The key national data tools utilized in the management of sexual violence include the Post Rape Care (PRC) form, a rape trauma counselling and, the Kenya police medical examination form (also referred to as P3) to document the history and evidence obtained from survivors, and services offered (Ministry of Health, 2016). In addition to offering clinical management and psychosocial support, health providers are required, first and foremost, to document their findings in the Post Rape Care (PRC form). The PRC form is filled in triplicate for each survivor of sexual violence. The original forms are forwarded to the police, a duplicate copy is given to the survivor, while the third remains in the facility. The PRC form captures the client's socio-demographic information; details of the assault-type, date of the assault, time of occurrence, perpetrator/s (if known), and location of the incident; contact information of the survivor, date and time of examination, number of perpetrators, sex and age, location of the incident, and whether or not condoms were used. Other information collected include date and time of the report to police, date of presentation at the health

center, evidence and samples obtained from survivors, the treatment offered; referrals made to other health and non-health related services. Additionally, information on significant, relevant medical or surgical history, physical examination results, forensic evidence, genital examination, and psychological state of the survivor is captured by the form, as well as the chain of custody including name and signature of the attending health provider and the police officer who collects the forms from the hospital upon completion by a health provider. The information captured on the PRC form is also entered into the health facility SGBV register which captures the survivor's socio-demographic information, the date of the assault and date and time of reporting to the health center, time taken to report incidence, contact details, as well as details of the assault, tests conducted, results of these tests, treatment and the counselling schedule maintained for each survivor, referral status and follow up details including dates of the next appointments. The SGBV register is utilized to record all visits made by the survivor, and the services offered.

On a monthly basis, the provider is required to summarize the PRC data from the SGBV register onto the SGBV monthly form. This is meant to capture the key indicators for reporting this information through the Kenya Health Information System (KHIS) data portal for all health-related data. These indicators include a summary of survivors seen in a facility, the number presenting within 72 hours, the number initiated on various treatments including HIV PEP, the number tested for HIV and those who tested HIV positive, as well as those who became pregnant. The P3 form, on the other hand, is only issued to survivors who report the assault to a police station, and it is filled in by both the police and the health providers. The documentation filled in for survivors' forms serves as part of the evidence presented in court

by health care providers in instances where survivors want legal action taken against the perpetrator.

Despite the clearly outlined process, healthcare providers still face challenges in the management of sexual violence survivors. A study on the challenges experienced by service providers in the delivery of medico-legal services to sexual violence survivors in Kenya indicated that quality of services offered is often compromised due to delayed reporting by survivors either from the community or the police. Survivors take long to report, in addition to providers not adequately documenting services offered to help inform the package of care to be provided across the different departments (Ajema et al., 2011). To date, there is limited evidence supporting the extent to which quality of PRC can be strengthened through improved documentation of services offered to survivors.

A review of PRC records conducted in one of the largest referral hospitals in Kenya revealed significant gaps in the utilization of the PRC forms (Kuria et al., 2013). These gaps ranged from lack of complete documentation of service offered to lack of understanding or l mechanisms to link the facility data with the police data and other sectors where the sexual violence cases were reported to. This thesis, therefore, provides insights into the status of PRC documentation in county-level facilities across the chain of evidence which constitute a majority of health facilities in Kenya. Findings from this study will help bring to fore measures to be put in place to enhance the quality of PRC documentation across sectors.

Although the medico-legal process for the sexual violence has been well outlined in the National Guidelines for the management of survivors of sexual violence, there is evidence that the interface between the medical and legal sectors has been neglected. There is a gap between the documentation of evidence by various service providers across the chain of care

hence difficulty in establishing uptake of cross-sectoral referrals made (Ajema et al., 2008). Similarly, there is a poor attitude from police and insensitivity by law enforcement officers who do not investigate and effectively prosecute the perpetrators (Onyango, 2008). Additionally, survivors have over time reported insensitivity in the criminal justice system, which is often portrayed in delayed or lack of prosecution of the perpetrators and dismissal of cases by the court (Onyango, 2008). These findings highlight the need to strengthen the medico-legal aspect in the management of sexual violence.

2.7. Current sectoral specific responses to sexual violence in Kenya

The sexual violence response mechanisms in Kenya hinge on the legislative framework which includes the Constitution of Kenya in which basic human rights have been enshrined, the national sector-specific sexual violence-related guidelines, and other legal statutes such as the Sexual Offences Act which outlines the various forms of sexual violence (Government of Kenya, 2006b). The Sexual Offences Act medical treatment regulation (2012) dictates that PRC services be offered at no cost (Government of Kenya, 2012), and the Witness Protection Act (2006) provides mechanisms to enhance the safety of survivors and vulnerable witnesses (Government of Kenya, 2006a). According to the National Guidelines for the management of sexual violence in Kenya 2014, the enrolment of a survivor into care ought to commence immediately in accordance with the different sectoral policies. These sectors include:

The Health System: The health sector plays a key role in the provision of clinical and psychosocial care to survivors of sexual violence and subsequent referral for legal aid and/or protection (Bott et al., 2004). The WHO guidelines prioritize violence against women as a health priority (WHO, 2013). A study by Bonomi et al. revealed higher utilization of health

services by abused women in comparison with non-abused women due to the mental trauma and other ill-health outcomes associated with abuse (Bonomi et al., 2009, García-Moreno et al., 2015). The motivators behind preferred reporting to health facilities first include prevention of STI/HIV infections through receipt of timely prophylaxis, the need to have forensic evidence retrieved and analyzed in a timely manner, in addition to securing the necessary reports for judicial proceedings (Melek et al., 2006).

Consistent with this practice, many studies have highlighted the critical role played by the health sector in addressing sexual violence-related consequences (Tsai et al., 2016). In Canada, a study on the help-seeking practices in a sample of 1167 survivors identified the health sector as the most preferred source of support, followed by the police (Ansara and Hindin, 2010). A study conducted in rural Uganda associated the health sector with the provision of psychological first aid to address mental outcomes associated with sexual violence (Tsai et al., 2015). This also resonates with an assessment done by UNFPA in India that revealed the key role played by the health sector in the identification of cases of abuse and provision of appropriate management of injuries and other GBV related symptoms (Melek et al., 2006). However, weak referrals to mental health services within the health sector was documented in a study conducted in South Africa (Williamson et al., 2017). This study further highlighted the important role played by caregivers in supporting children who had been violated. However, caregivers from the 20 households interviewed in the same study indicated difficulty in supporting their children through therapy either due to costs involved, distance to the hospital or the presence of poor follow-up mechanisms. The importance of a strengthened health sector and combined response to sexual violence has been documented in a study conducted in Congo that revealed the importance of integration

of sexual violence services in primary health care (Casey et al., 2011). Although the three studies in rural Uganda, India and Congo clearly highlight the importance of the health care system in addressing sexual violence, a multi-sectoral approach will be required to holistically address sexual violence issues.

The health sector response is not different in Kenya, where institutions to which cases of sexual violence are to be reported are outlined in the National sexual violence guidelines. However, in Kenya, the choice of where to report first is mostly made by the survivor based on the proximity of the facility to where they geographically are and/or the services offered. The services offered differ from one level of care to the other based on the provisions within the policy frameworks, staffing, infrastructural provisions and available equipment. For example, the health package offered at the level one, which comprises the community, involves identification and referral of survivors to the nearest health facility by community health volunteers. The next level comprises health centers and dispensaries that can only offer an immediate first dose of Post Exposure Prophylaxis (PEP), Emergency Contraceptives (EC) and manage injuries before referring a survivor to the county and sub-county hospitals. The County and referral hospitals in addition to offering the package of care offered at the lower levels also undertake forensic examinations, complete medico-legal forms, undertake laboratory investigations, offer trauma counselling, and refer the survivor to the police for legal aid and investigations (See Table 1 above for the staffing and service expectations for each level of care). These differences highlight the fact that comprehensive help should be sought from National referral hospitals, County and Sub-County hospitals where post rape care is provided (MoH, 2014), by providers who have been trained on management of survivors of sexual violence and with the presence of a well-equipped and functional

laboratory to undertake clinical and forensic investigative tests (see Table 1 above for a further explanation on the service package per level of facility). The health sector is usually the first point of reporting for most survivors (Wangamati et al., 2017b). This is important because medical care is provided to manage injuries if any, provide first aid, HIV post-exposure prophylaxis, Emergency Contraception and STI treatment. The role played by the health sector is not limited to providing health-related services but also linking survivors to other sectors for legal aid and social support (García-Moreno et al., 2015, UNFPA, 2015). The health sector is integral to the provision of health-related services, documenting evidence critical for judicial processes and linking survivors with institutions that offer social support (Kamimura et al., 2013), rehabilitation and legal redress (Decker et al., 2018). Hence the importance of enhanced quality of data collected by the health sector and the need for a functional referral pathway for survivors, evidence and data collected. Consequently, some countries including Kenya (TFSOA, 2013), Zambia (Government of the Republic of Zambia, 2010), Malawi (Government of Malawi, 2014), Liberia (Gender-Based Violence Interagency Taskforce, 2006) and the Philippines (Ministry of Health, 2012), have in place in theory at least, multisectoral GBV guidelines (Keesbury and Askew, 2010). The health sector also plays a critical role in facilitating the collection of forensic evidence that is key for instituting criminal proceedings against perpetrators (Kilonzo, 2008).

Legal Sector: The Government of Kenya has developed legislative frameworks that include: (i)The Sexual Offences Act of Kenya (TFSOA, 2013) which provides for the definitions and penalties of the various unlawful sexual acts (Government of Kenya, 2006)ᵣ. In addition, there is (ii)The Children's Act, Revised Edition 2012 which provides for the rights, protection and care of children; (iii) The Witness Protection Act, 2006 also previously mentioned which

provides for the protection of witnesses in criminal proceedings; (iv) The Criminal Procedure Code, Revised Edition 2012 (National Council for Law Reporting with the Authority of the Attorney-General, 2012); (v) The Evidence Act 2014; and (vi) The Bill of Rights as enshrined in Chapter Four of the Constitution, 2010 (National Council for Law Reporting with the Authority of the Attorney-General, 2014; National Council for Law Reporting with the Authority of the Attorney-General, 2012).

The Kenyan SOA has existed for the past 12 years, providing guidelines for the defining and criminalizing sexual offences and establishing regulatory measures for handling cases of sexual violence. However, recent studies show that many Health Care Workers (HCWs), community leaders and police officers, who handle matters regarding sexual violence, remain ill-informed of the provisions of the Act. For instance, a study conducted in Kenya by Wangamati revealed that providers lacked requisite knowledge on the management of sexual abuse cases and that most facilities did not have copies of the required policy frameworks to inform service delivery (Wangamati et al., 2017a). It also appears that service providers do not always provide quality and/or standardized services to survivors of sexual violence who present themselves for care in the different institutions (Wangamati, 2014). This may not be specific to Kenya as evidence was obtained in an assessment that was undertaken on the quality of services in three clinical forensic medical services in South Africa., which revealed discrepancies in the provision of therapy either due to non-uniformity in the application of National Guidelines, and/or lack of the required support from management (Skosana, 2016).

Criminal justice system[3]: In many jurisdictions, the police are the custodians of the evidence collected by the health care workers and the gateway into the criminal justice system for survivors of sexual violence (Du Mont, 2007). Survivors are required to report to the police station in order for them to be able to receive comprehensive medical-legal care and the P3 form, a legal document filled in at the health facility. Survivors who first report to the police stations are issued with an Occurrence Book number and in some instances, a P3 form subject to its availability. Where the P3 form is not available at the police station, the survivors get referred to where they can obtain copies of the same, mostly by downloading from the police website through the use of cyber cafes neighboring the police station. The survivors are thereafter referred to the hospital for a medical examination, evidence collection and documentation on both the PRC and the P3 forms. The police are required to collect original copies of both the filled in PRC and P3 forms from the health facility for onward case progression to the court (Shako and Kalsi, 2019a).

A comparison to other countries highlights challenges which are similar to what is experienced in Kenya with a focus on legal proceedings and redress. For instance, in Sudan, the law bars health care providers from attending to such cases until a report is made to the police (Abuelgasim, 2018). Hence survivors who fail to report to the police in order to be issued the requisite legal form, miss out on receiving medical care. A study in South Africa showed that 85 per cent (n=3515) of survivors did not receive the full package of medico-legal care due to non-disclosure of a sexual violence incident to the police (Meinck et al., 2017). A study conducted in Columbia revealed that survivors' failure to report to the police was due to the fear of retaliation from perpetrators (Wirtz et al., 2014). However, in Uganda,

[3] The criminal justice system herein includes the police and the legal sector

while cases are reported to the police, a majority of these cases do not end up in court. Reasons for this include community member bypassing the legal system either due to fear of being stigmatized by police or community, costs involved in travelling to the police station or paying a certain fee in order for a case file to be opened, lack of skills by police in collecting evidence, and the inability of the police to visit the crime scene or health facility to collect evidence or doctor's report (Liebling-Kalifani and Baker, 2010).

Evidence shows that the arrests are more likely only when the perpetrator is well known in comparison to a stranger, as demonstrated in a study conducted in the USA (Pattavina et al., 2016). Whilst the police represent a very critical point in response to sexual violence, data obtained by the Human Rights Watch on the atrocities committed during the Kenya 2017 electioneering period, suggests few cases of sexual violence get reported to the police (Human Rights Watch, 2017). There are a number of reasons for Kenyan survivors not reporting sexual violence to the police. These include embarrassment, fear of revenge from perpetrators or their family, protracted legal processes, and shame associated with sexual violence (Wolitzky-Taylor et al., 2011; Cohn et al., 2013; Human Rights Watch, 2017). A study utilizing a mixed-methods design using qualitative and quantitative methods study conducted among 50 women who were survivors of sexual assault in a Kenyan informal settlement revealed that only 25% of them reported the assault to a police station while the rest opted to report to a health facility or Non-Governmental Organizations (Syombua, 2014). A similar study revealed negative survivor experiences with the police who at times ridicule, verbally abuse, and dismiss cases of sexual violence reported to them (Wangamati et al., 2016).

The police are supposed to serve as the liaison between the health sector and the judicial system and are required to investigate all cases of sexual violence reported to them.

Contrarily, the Human Rights Watch in Kenya revealed hesitance by police to investigate cases of sexual violence perpetrated specifically by fellow police officers (Human Rights Watch, 2017). Evidence from other developing and developed countries show reluctance by police to pursue criminal matters, particularly sexual violence cases reported to them with limited corroborative evidence, due to a variety of reasons (Wentz and Keimig, 2019). In South Africa, the unwillingness by the police to pursue cases of sexual violence is linked to a desire by the criminal justice system to demonstrate a reduction in crime rate, and the lack of mechanisms in place to guarantee complainants of their safety (Holton et al., 2018). In Tanzania, the existence of corruption amongst the police force has been documented as a deterrent to reporting of cases of sexual violence (Abeid et al., 2014). A study conducted in the US revealed a high probability of sexual violence-related arrests only in instances where there was strong corroborative evidence, whether forensic or physical (Tasca et al., 2013).

Community roles and response mechanisms: Socio-cultural norms are a key influencer to the use or non-use of violent behaviors by individuals (World Health Organization, 2009, Laisser et al., 2011; Kalra and Bhugra, 2013; Mannell et al., 2018). A study undertaken in Tanzania linked the occurrence of sexual violence with gender inequality and negative forms of masculinity (Laisser et al., 2009). In the case of sexual violence, community structures [4]have been documented to play a key role either as enablers or barriers to reporting of sexual violence cases to the police or health facility (Syombua, 2014; Mannell et al., 2018). There are variations and similarities in how communities in other countries handle cases of sexual violence compared to Kenya. For instance, in Uganda, evidence obtained from

[4] The community sector includes national and international non-governmental organizations Cruz, G. V., Domingos, L. & Sabune, A. 2014. The characteristics of the violence against women in Mozambique. *Health,* 6**,** 1589., community-based organizations (CBOs), religious organizations, traditional Healers, youth organizations, women's networks, networks of people living with HIV/AIDS (PLWHA), Media houses and special interest groups.

male survivors of sexual violence shows that cultural taboos around male sexual violence impede reporting by male survivors (Schulz, 2018). According to the survivors, the culture of silence around male violence contributes to the non-reporting of cases. In addition, one is not considered to be masculine if they report that they were violated. In Tanzania a qualitative study documented that most cases of sexual violence get resolved through local arbitration mechanisms owing to the normalization of GBV, a result of the patriarchal society and existing gender inequalities that favor men (Muganyizi et al., 2009). Another study carried out in Tanzania showed that survivors do not obtain justice for cases reported to law enforcement as the law enforcers refer survivors to community leaders for local arbitration between the survivor's family and the perpetrator (Abeid et al., 2014). In Liberia, preferences for community resolution of rape cases is associated with corruption in the judiciary system, the perception that formal structures are not reconciliatory in nature, and fear of stigmatization by the community and/or service providers (Isser et al., 2009; Medie, 2013). Further, a study conducted in Harare, Zimbabwe, associated the non-reporting of cases of sexual violence to limited awareness by community members of the available services (Sithole et al., 2018). While in Ethiopia, the non-reporting of sexual violence in intimate partner relations was linked to fear of stigmatization by the community (Abeya et al., 2012). The gaps in community response mechanisms also corroborate previous research conducted by Freccero et al. (2011), who discussed the taboo associated with discussing matters of sex and sexuality in most cultural contexts in Kenya. Furthermore, a qualitative study conducted in Kenya revealed that the gender inequalities and harmful practices associated with sexual violence, such as victim-blaming and ostracization of survivors were barriers to reporting for care (Wangamati et al., 2018). The stigma associated with sexual violence poses a challenge in the effective responses that involve the community. This thesis, therefore, documents

current reporting patterns of sexual violence in Kenya from a survivor and a community leaders' perspective. The objective is to provide evidence on how multi-sectoral referral mechanisms can be enhanced while being cognizant of the socio-cultural sensitivities around sexual violence in Kenya and broader Sub-Saharan Africa.

In an effort to help address distance as a gap in access to service delivery, a mobile outreach service delivery approach targeting vulnerable women in rural communities with health services including those GBV related was piloted in Northern Kivu, Congo. In this model, mobile clinics were taken to various sites in six villages and 772 patients, 85 per cent who were survivors of sexual violence were offered the services and referred for further specialist care. A review of this model showed that while 72 per cent of the survivors returned for the first follow up visit, there was a significant drop to 7 per cent and 3 per cent for the second and third follow up respectively. In addition, these services were mostly accessed by women aged above 20 years. Those aged below 20 years reported not accessing care for fear of being ostracized by their future in-laws or being labelled promiscuous (Kohli et al., 2012). While mobile clinics help breach the immediate gap in inaccessibility of services, they do not address long-term gaps in PRC service provision such as enhanced follow-up and retention to care, and improving service utilization by children and adolescents who form the majority of survivors of sexual violence in most countries.

In Kenya, the community plays a key role in sexual violence with a focus on identification of perpetrators, encouraging the reporting of sexual violence-related cases, referral of survivors for care, and preservation of the evidence at the scene of the crime (Shako and Kalsi, 2019b). However, there is evidence of limited awareness in the community on how to preserve the crime scene. Certain cultural taboos contribute to tampering with

evidence, especially in incestuous related cases of sexual violence, in order to protect the perpetrators (Syombua, 2014). Available evidence shows instances in which the local administration and opinion leaders compromised cases of sexual violence reported to them either due to lack of knowledge on the provisions of the Sexual Offences Act and the health-related services available or due to them having been bribed by the perpetrator or their family (Ajema et al., 2011b; Kilonzo et al., 2009b). The commission into the inquiry of post-election-related violence in Kenya reported instances where local leader's inaction to cases led to delayed or no reporting of cases to the hospitals or police stations (Waki, 2008).

In Kenya, there is documented evidence that survivors who fail to receive support from community structures most often report to the police and/ or hospital as their last resort (Odero et al., 2014). Some of the survivors choose to report at a facility that is quite a distance from their community due to fear of stigma thus impeding their ability to adhere to treatment needed (Odero et al., 2014). This trend greatly increases survivors' vulnerability to HIV/STI infection, unwanted pregnancies, and in some extreme cases to death due to lack of timely reporting and referral for post-rape care. Community health volunteers (CHVs) play an important role in the management of survivors of sexual violence. Research shows that CHVs often form the first point of reporting of cases in the community by virtue of their being the community's own resource persons (Gatuguta, 2018). However, limited evidence exists on the referral pathways from the community structures or CHVs to either the police and/or hospitals.

2.8. The rationale for multisectoral responses to sexual violence

Survivors of sexual violence, as shown in the previous sections, have multiple needs and require a variety of services, hence the need for them to engage with different sectors

for health, safety, and legal redress. The multi-consequences of sexual violence often require survivors to navigate through the health, social and legal systems, which might result in attrition to care or delayed uptake of services. There is a global recognition for a system based holistic response to sexual violence through coordinated efforts of actors and sectors which respond to the multi-faceted needs presented by survivors of sexual violence (Jewkes, 2016; World Health Organization, 2017). However, there is limited evidence on the extent to which systems and services are coordinated and provided for, for these multi-faceted needs. A systematic review of global evidence through the Lancet series on the state of health sector response to violence against women underpins the need for coordinated referral and follow up mechanisms of survivors (García-Moreno et al., 2015). The review further highlights that while the survivor entry point to care is varied, there is the need for coordinated survivor centered care, as outlined in Figure 2 below. The review outlines the key components essential for a coordinated response to sexual violence. For purposes of this study, the critical component revolves around the need for systematic protocols that govern service delivery and referrals within and across sectors. A coordinated response is also dependent on the service delivery model in use to deliver services to survivors of sexual violence.

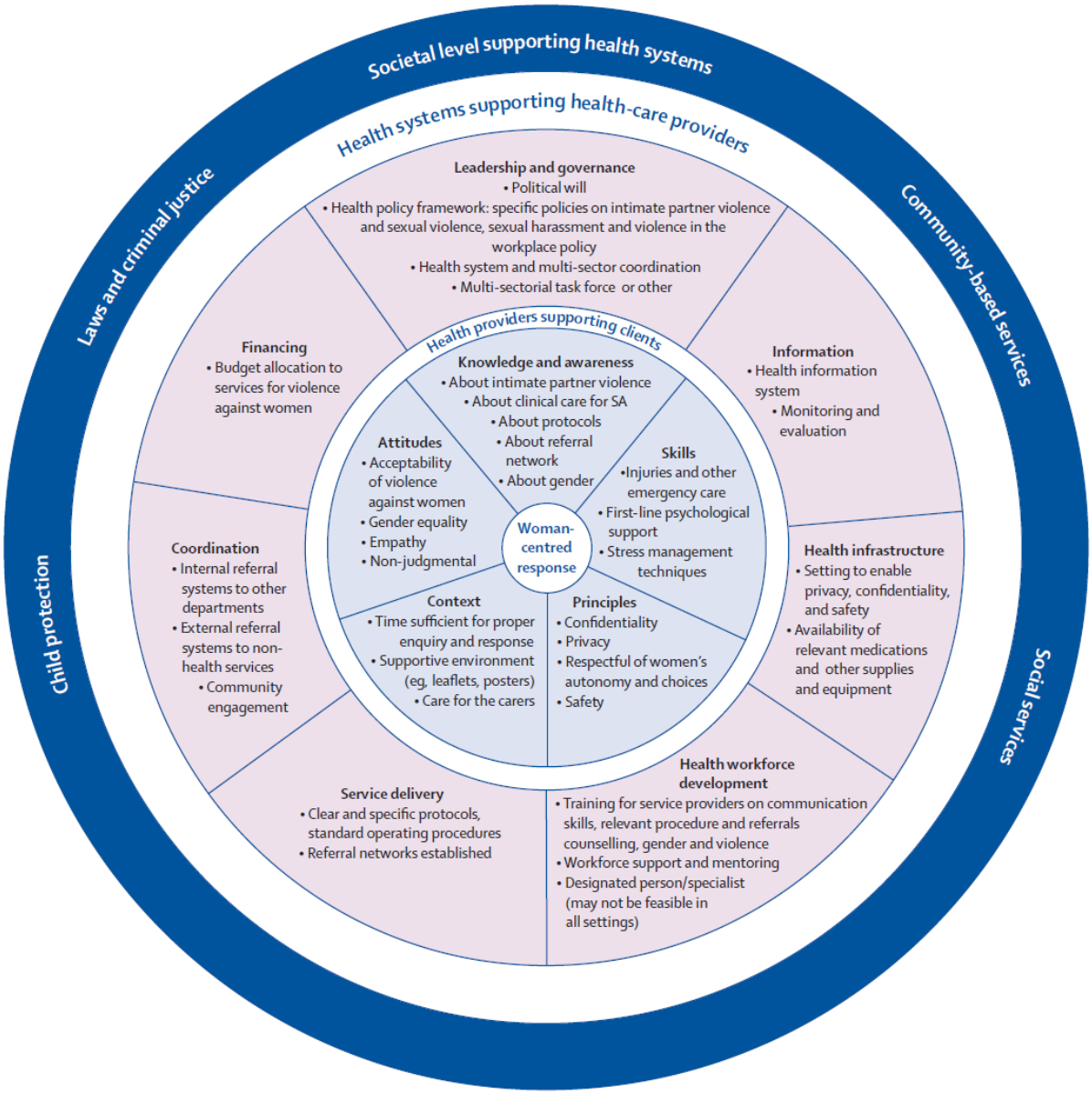


Figure 2: An integrated response mechanism for survivors of sexual violence [5]

A review of the Sexual Assault Nurse Examiners (SANE) program in the USA highlighted that their role could enhance a timely and coordinated survivor-centered response (Littel, 2001). However, the review pointed out the need for an enhanced collaborative engagement from community structures, through community sexual violence advisory boards and other formal structures. In addition, it was recommended that the

[5] *Adapted from Garcia Moreno, et al (2014) on health sector response to violence against women (García-Moreno et al., 2015)

location of the service delivery points within the health facility should be informed by measures that will enhance survivor safety, ease of movement and timely referral to other health services in departments that should be close to each other. A qualitative study carried out in three public health facilities in South Africa, explored the personal experiences of sexual assault survivors to understand the facilitators of, and barriers to the uptake of follow up care. The study found that patients missed out on the complete package of care due to the failure by health care providers to integrate mechanisms to facilitate follow up of survivors of sexual violence. Negative perceptions, based on other survivors or survivors' personal prior experience of police, judicial and health care systems, were further barriers to follow-up care, highlighting the need for coordinated referral and follow up mechanisms for survivors across sectors (Holton et al., 2018). Also, the study indicated that providers place more emphasis on HIV prevention for those who test negative and place limited focus on the need for comprehensive follow up for mental and physical health-related needs. Similar evidence from Malawi revealed survivor loss to follow up was a result of poor coordination between departments and actors involved in the provision of PRC services (Mulambia et al., 2018). This mixed-method study targeted both survivors and guardians to child survivors to explore their experiences with care at Blantyre One-Stop Centre at Queen Elizabeth Central Hospital. The study findings showed that the fear of HIV infection was a strong reason why 80 per cent (n=107) patients returned to the facility for HIV follow up test three months after the assault. However, the study showed difficulties in determining the correct referral pathways for child survivors due to failure by providers to document cases attended to and referred for further care (Mulambia et al., 2018). Evidence drawn from South Africa on the uptake of mental health-related services by survivors revealed the lack of an integrated service delivery model as the reason for client failure to follow up and uptake of counselling

services. In addition, counselling services are to be offered over a long period ranging from months to years; hence the need for long term follow up to facilities often run by NGOs. However, cost implications associated with access to services offered by Non-Governmental Organizations (NGOs) remains a barrier to access (Abrahams and Gevers, 2017). This resonates with the Kenyan context where counselling visits are scheduled at visit one and thereafter at three and six months after the sexual violence assault, more so for those tested HIV negative (Gatuguta et al., 2018). The follow-up visits are mainly linked to confirmation of one's HIV test and level of adherence to PEP.

2.9. Multi-sectoral referral pathways for survivors in Kenya

Mechanisms meant to foster the implementation of a multi-sector referral of survivors and follow up of referrals made have been outlined in the Kenya multisectoral SOPS for prevention and response to sexual violence (TFSOA, 2013). However, there is a lack of systematized referral protocols across the different sectors that need investigation. This makes it challenging to facilitate the delivery of standard comprehensive care to survivors. This disconnect between different sectors has resulted in inconsistencies in services accorded to survivors; duplication of efforts by stakeholders, and frustrations faced by survivors in having to access services that are spread out in different offices (Kilonzo et al., 2013). The referral pathway for survivors differ from sector to sector and are also influenced by the survivor's first point of reporting-community, police or health facility. In a study conducted in Kenya, the need for cross-sectoral integrated approaches to referrals was noted (Kilonzo et al., 2009c). However, this gap persists despite efforts to address this through the formulation of a multi-sectoral Standard Operating Procedures for sexual violence in Kenya.

Figure 3 below indicates the pathways taken by survivors who can either directly report to a health facility, police or community. Community resource persons who include community health volunteers, paralegals, and local leaders, assist the survivors and seek legal redress as well as refer the survivor to hospital.

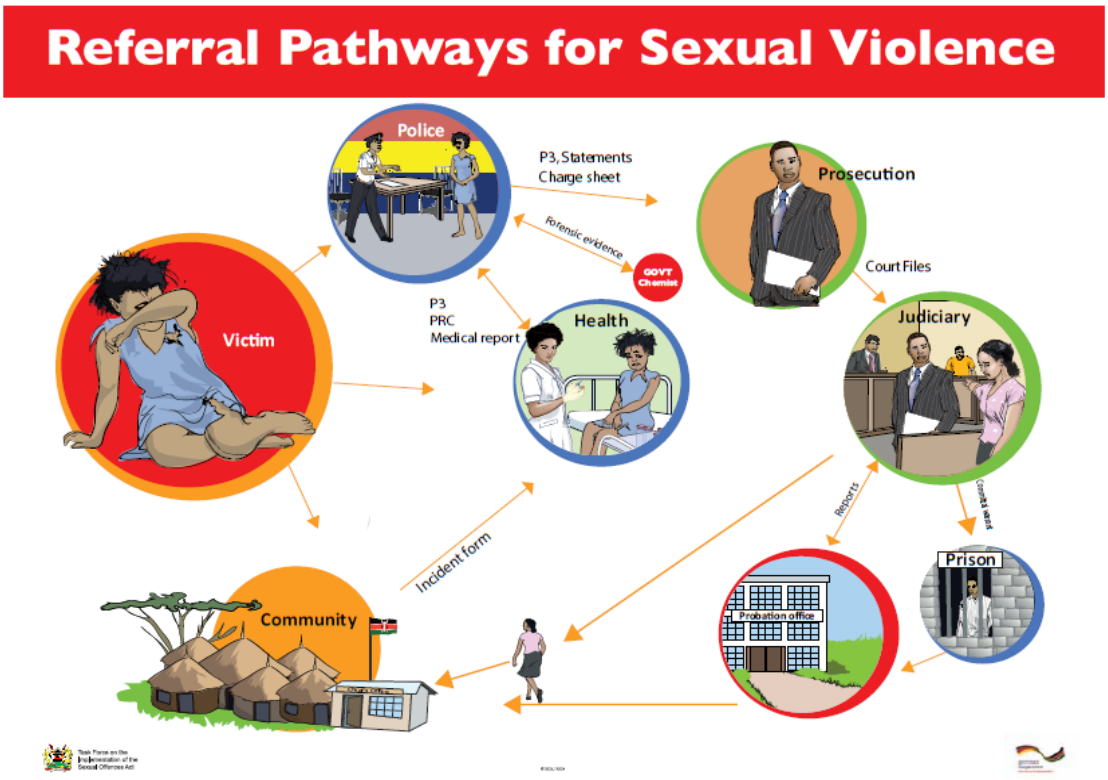


Figure 3: Referral pathways for survivors of SGBV in Kenya[6]

The police utilize the filled in P3 form and original copies of the PRC form and evidence obtained for survivors to commence investigations as illustrated in Figure 3 above. The police, therefore, serve as an important link between the hospital and the prosecution. The judiciary besides playing a role in the legal determination of cases also links the survivor with the social department to enable them to receive the required support, protection and

[6] Source: Multisectoral SOPs for prevention and response to sexual violence, Kenya

re-entry back into the community to avoid community hostility once the perpetrator is incarcerated.

2.10. Service delivery flow in access to services by survivors of sexual violence in Kenya

Within the public health facilities, survivors are often required to navigate across several service delivery points which are spread out in different locations - laboratory, outpatient, counselling, care clinics and pharmacy to access various components of PRC services. Upon entry in a hospital, the survivor presents themselves at casualty or emergency department for physical examinations, history taking, injury management, prophylaxis, and documentation. Thereafter, based on the condition of the survivor, they are referred to the laboratory for sample taking and analysis; to the counsellor for immediate psychological first counselling then back to casualty for determination of the treatment plan. The survivor is then sent to the pharmacy to get the necessary medication, as indicated in **Error! Reference source not found.** below. A follow-up plan is drawn up before the survivor is advised to report to a police station of their choice for legal action. However, it is not clear what methods should be used to refer survivors from one department to the other within the health facility. This is due to the lack of standard PRC related referral tools for use within the health facility, as well as outside for legal support. Furthermore, a centralized approach to service delivery is a key determinant to the reduction in costs of access, of time spent in accessing services and high attrition during care-seeking due to complex referral pathways that are not clearly understood by all.

The web of referrals within a health facility is a hindrance to survivors receiving comprehensive care. A study in South Africa revealed that the rate of referral of survivors at the emergency department is often dependent on the provider's "mood" on a particular day.

Also, not all providers that feed into the survivor referral pathways across the different sectors have been trained on PRC which result in delays in initiating care upon receipt of a case, or lack of knowledge on what service to offer and where else to refer the patient (Gihwala, 2016). In a qualitative study conducted by LVCT Health in Kenya, in two public health facilities, survivors cited frustrations such as having to narrate their complaint to providers as well as having to queue at each of the service delivery points, they were referred. In addition, the service delivery points within the facility were found to be between 20 to 50 meters apart hence strenuous for survivors, having just suffered a sexual violation to move between the service delivery points. This is particularly the case for child survivors who were accompanied by elderly caregivers (Kiruki et al., 2017).

According to the National guidelines on the management of sexual violence, all health facilities are required to display a poster outlining the client flow for survivors of sexual violence in their service delivery points and waiting bays (see Figure 4 below)

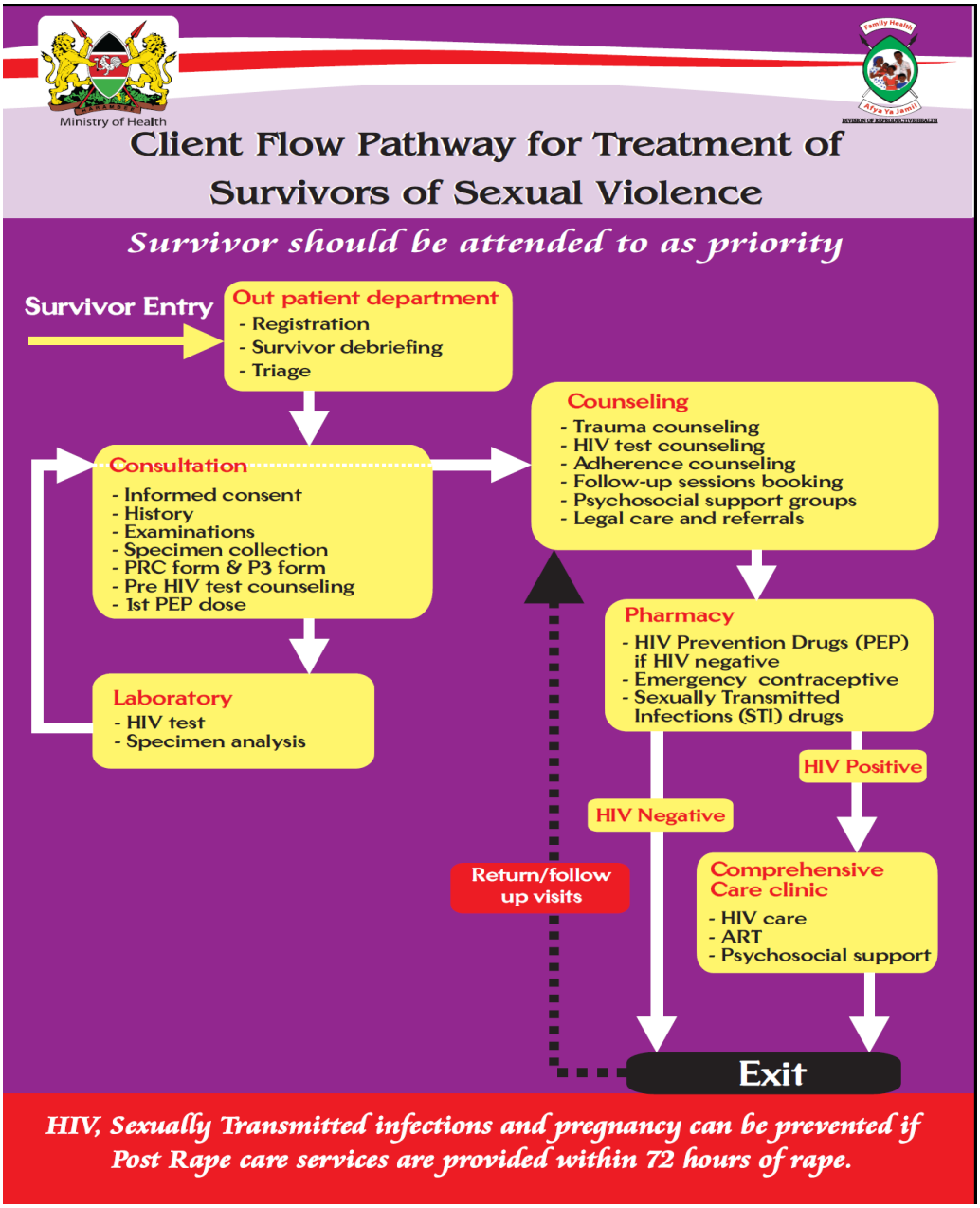


Figure 4: Client flow pathways for survivors within a health facility

Health facilities in Kenya are required to provide signage to guide survivors on which is the first department to report their complaint to upon presentation. In most cases, this is the Outpatients Department (OPD) t. Hospitals are also required to have a service charter on the walls of each department together with an outline of available services, waiting times before being attended to and the cost associated with each service. This should include information on cases where there is a waiver associated with a service, such as PRC.

However, in practice, and in some facilities, no posters illustrating the pathway of care are displayed at the OPD. This results in survivors' inability to determine the different service delivery points they are required to visit (Kiruki et al., 2017). The posters are important for survivors who do not wish to narrate their ordeals at the hospital front desk, which often do not offer privacy to patients and are manned by providers not necessarily trained on PRC case identification and referral. Worth noting is that even in facilities where the referral pathways are displayed, they are only comprehensible to patients who can read English. The posters are yet to be translated into other local languages by the Ministry of Health. There are also no posters showing referrals to and linkage mechanisms for survivors required to access services outside the health facility. It is therefore left to the discretion of the provider, who has this information, to share the same with survivors. No study has been undertaken in Kenya to examine the efficiency in the referral pathways and processes with a focus on the different sectors involved in the management of sexual violence.

2.11. A theoretical framework for this study:

The study was informed by the Anderson health utilization model (Andersen and Newman, 1973; Andersen, 1995). This model provides a framework for the determination of factors that contribute to an individual's use (or non-use) of health services. According to this model, three key factors play a significant role in influencing health-seeking behavior. These include i) *predisposing factors* which entail an individual's socio-cultural characteristics and social structural factors. Examples of predisposing factors include age, sex, marital status, education, attitude towards services and values towards seeking help; ii*) enabling factors* – refers to the resources available to the individual to facilitate access to services. Examples include time and money; and iii) need factors which revolve around an individual's own

perception of their health status and the need to seek help. This model is illustrated in Figure 5below.

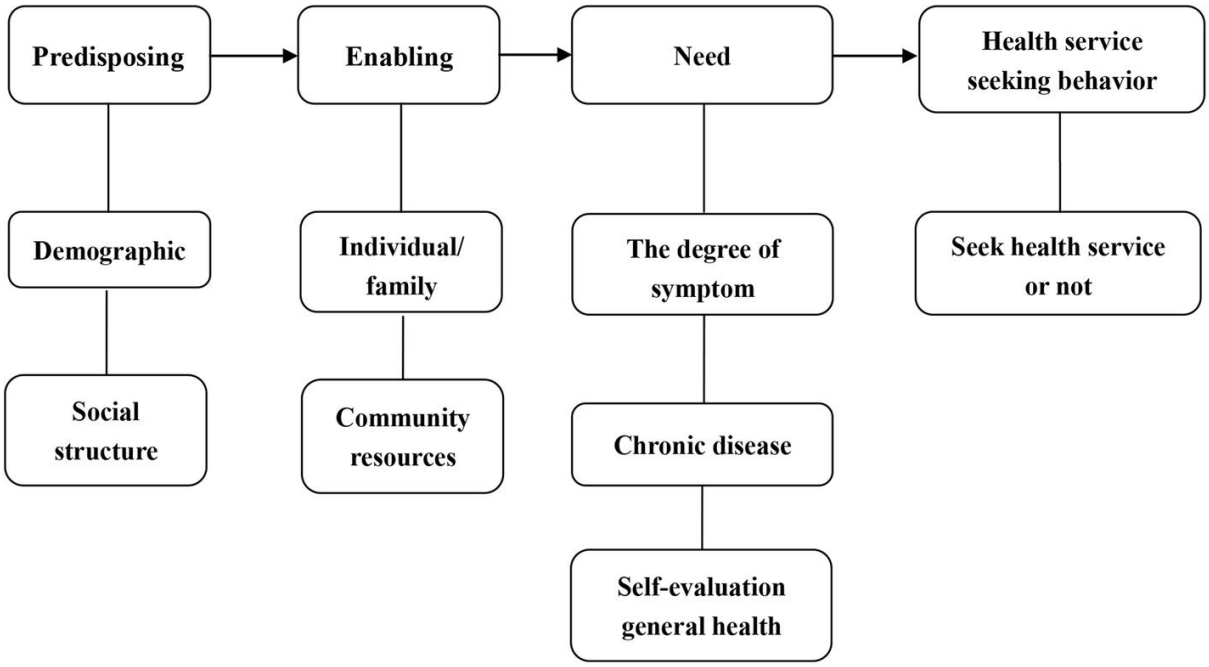


Figure 5:Illustration of the health services utilization model[7]

Based on the health utilization model, this study focused on four key parameters- social norms that hinder or facilitate reporting of cases of sexual violence, organization of the PRC service infrastructure (from a survivor's perspective), individual behavior (both survivors and providers) in navigating through the various services, and structures in place to facilitate the provision of comprehensive care.

Social factors and norms have been cited for contributing to the occurrence of sexual violence, such as gender inequalities and poverty (Akmatov, 2010). Evidence shows that children from poor families are at higher risk of sexual violence, as some are compelled by their socio-economic status to trade their bodies for food or enter into early marriage to

[7] *Source: Adapted from Analysis of health service utilization of migrants in Beijing using Anderson health service utilization model

older men (Wangamati et al., 2018, Goodman et al., 2009). In addition, the social construction of acceptable behaviors also fuels the occurrence of sexual violence or serve as a deterrent to report. For example, most communities promote negative forms of male masculinity, that is, male entitlement to sex and limited consideration to matters of consent. This is exacerbated for those in intimate partner relationships (Hillis et al., 2016). Research in Low and Middle-Income Countries (LMICs) highlight the continued vulnerability of children and women to sexual violence (Stoltenborgh et al., 2011; UNICEF, 2014a; Decker et al., 2015). Consistent with prior evidence, women and children in Kenya are at increased risk of sexual violence (NPS, 2019). Social norms around sexual violence played a key role in influencing survivor behavior towards reporting a sexual violation. Community and an individual's perceptions towards a given occurrence of sexual violence determine their response, i.e. whether to seek help or remain silent. Evidence from sub- Saharan Africa associates non or delayed reporting of sexual violence with community beliefs that "normalize" sexual violence, consider it a taboo to discuss sexual matters with strangers or report cases of abuse perpetrated by relatives or persons well known to the family (Tran et al., 2016). This, in turn, contributes to missed treatment opportunities by survivors who present for care beyond the stipulated timelines. This study established that the continued late reporting of survivors for care, is either due to stigma associated with rape, or fear of being victimized by either the community, perpetrator or service providers. Similarly, a study conducted in Kenya highlighted a 'culture of silence' as a major influence on the decision taken by survivors on whether to report a violation or not (Plummer and Njuguna, 2009).

Organization of services: How the services are organized is another important determinate of the utilization of sexual violence related care. Organization of services

comprises the accessibility and service layout of the various departments involved in the provision of care. Within the context of sexual violence, survivors interact with providers drawn from the health, as well as their interaction with the police, legal, social sectors in their pursuit for medico-legal services and psycho-social support. Survivor entry points into care are defined at the facility level and the National guidelines whose applicability is further determined by the level of the facility. In most countries, survivors access PRC services through defined departments where the service package is well defined (Muthoni, 2019; Gevers et al., 2015). Each of these institutions has varied approaches to their operations with a focus on hours within which services are offered, documents filled in for each case, costs associated with access, and client movement from one office to the other. Varied models of PRC service delivery have been expounded in section 2.4 of this thesis. However, limited evidence exists of evaluations that have been undertaken to assess the effectiveness of models of delivery.

An individual's behavior: Another critical component to the model applied in this study is the survivor's behavior as a determinant for the uptake of services. An individual's perception of a problem determines their health-seeking behavior (Cornally and McCarthy, 2011). An individual's resolve to seek help is informed by circumstances that are unique to the situation at hand, and their demographics which determine their decision-making power as to whether to seek help and from which source. Help-seeking can, therefore, be seen as planned behavior that is defined by the issue at hand. This framework allows for an examination of an individual's behavior in order to generate meaningful conclusions on their reasons for seeking care or otherwise, their adherence to the treatment plan and measures in place to either prevent the occurrence of the problem or reach for support. In the context

of sexual violence, a provider's behavior and attitude towards a survivor also plays a key role in influencing the latter's health-seeking behavior.

Structural considerations in health utilization: The structural component to service delivery is highly interrelated to the other components. Structural mechanisms to sexual violence response play a significant role in enhancing survivor access to services. In most countries, there exist both formal and informal institutions where survivors can report a sexual violation. The informal systems are those based within the community. This lends itself to understanding the formal structure that supports or hinder assistance or help-seeking. This study focused on seeking to understand the formal structures to report cases of sexual violence. The focus was placed on the establishment of the first point of reporting of cases of sexual violence, processes undertaken in referring a survivor from one department or institution to the other, services offered, and the documentation maintained for each case. The national multisectoral guidelines on the prevention and response to sexual violence provide illustrative referral pathways for each sector in the Kenyan context. Despite this, limited evidence exists on the extent to which these frameworks aid in a better patient encounter with service delivery. One study conducted in Kenya showed that services in certain health facilities are only offered between 8 a.m. and 5 p.m. on weekdays, and survivors who report outside this schedule are forced to seek help elsewhere. Structural barriers contribute to delays in access to treatment and/or efficient client flow within departments hence high attrition.

In applying the health utilization model within the context of sexual violence, strategies that enable different sectors to engage in the management of cases from a primary, secondary and tertiary perspective need to be examined (Basile, 2015, Spivak et al.,

2014, McMahon, 2000). Evidence from Kenya shows that response to sexual violence requires survivors to access care from different entry points- health, legal, and/or community, rather than there being a comprehensive approach involving different levels and strategies (Gatuguta et al., 2018, Freccero et al., 2011). However, no study has been conducted to establish the functionality of the multi-sectoral pathways in Kenya, a gap in the evidence.

Different studies have employed the Anderson model. A study conducted in Ethiopia on the utilization of antenatal care services applied this model, from which certain comparisons can be drawn with this study (Tesfaye et al., 2018). The Tesfaye (2018) study sought to identify enabling factors and barriers to utilization of factors that either facilitate or hinder the utilization of Ante-Natal Care (ANC). This study used the model to establish current practices in the utilization of PRC services and influencing factors on report for sexual violence, medical, legal, psychosocial support. The Ethiopian study similar to this intended to link utilization of services with predisposing factors, such as age, marital status, and education; enabling factors such as availability of resources; and need factors like attitude towards the service and knowledge of pregnancy-related complications.

The application of the Anderson model may also provide a framework on which future studies on sexual violence may be hinged upon. This can provide a holistic understanding of the factors influencing utilization of PRC services and a determination of the strategic interventions that address the predisposing, enabling and need factors from a multisectoral approach.

Chapter 3 METHODOLOGY

3.1. Introduction

This chapter describes the study research approach and explains the methodology used (Creswell and Creswell, 2017). Delivery of post-rape care services in Kenya is undertaken by different sectors, hence the need to ensure observance of a continuum of care and the importance of a multi-sectoral approach (Kilonzo, 2007; Kilonzo et al., 2009b; Keesbury et al., 2012). The interconnectedness of the various sectors necessitated an examination of the management of survivors of sexual violence beyond the health sector to establish how the various sectors influence the delivery of comprehensive services, including how referrals for survivors are made. Understanding how different sectors provide care is important as these have a greater impact on the quality of care received and/or offered (Zungu et al., 2010). The qualitative component of the study recruited participants from the health sector, police, social services and judiciary to help understand the complexities involved in the delivery of services, the facilitators, hindrances and gaps in the delivery of services and how to enhance coordination in service delivery. In order to understand the complexities pertaining the referral of survivors, the study interviewed survivors of sexual violence (or their guardians) to help understand their experiences in navigating through the medico-legal system and upon taking referrals given. The quantitative component of the study involved an analysis of records maintained for survivors of sexual violence accessing services from these sectors.

The chapter provides a detailed description of the methodology used in this study with a focus on the study design; study sites, data collection and sampling approach, respondents, data management and analysis, and the ethical considerations. In this chapter, I also reflect on my own position in the study.

3.2. Study setting

This section describes the sites where the study was conducted.

i) Country Profile

Kenya is located in East Africa and has an estimated population of 47 million, with an average population growth of 1 million per year (Kenya National Bureau of Statistics (KNBS), 2019). Its economic growth, according to the World Bank, stands at an average of 5 per cent (Kenya National Bureau of Statistics, 2016). There are two national languages that are used in Kenya, English and Kiswahili, amongst several other tribal dialects. Kenya's economy is mainly agriculture driven.

In 2010, Kenyans voted in a new system of governance enabling devolution of powers from National to County governments. Under this new system, functions originally discharged by the Central government were transferred to Local Authorities, commonly referred to as Counties. There are 47 Counties each having county Governments constituted by County Assemblies and County executives. For this study, I targeted two Counties, for research, namely the Kiambu and Nakuru Counties. Kiambu County is adjacent to the northern border of Nairobi County and has a population of 1,623,282 people (Male - 50.2 %, Female - 49.8 %) (KNBS, 2010). The Kiambu county is predominantly rural with the people in the county being agriculturalist and engaging in small-scale businesses. Kiambu has four County hospitals, one of them being Gatundu county referral hospital, a site selected for this study (Kiambu County, 2001).

Nakuru County is the fourth largest county in Kenya after Nairobi, Kiambu, and Kakamega. It is predominantly urban with a population of 1,603,325. Naivasha town, which is located 90 km North-West of Nairobi, is one of the administrative divisions of Nakuru County

and has a population of 181,966 as per the 2009 census. Naivasha is located on the highway linking Kenya to Uganda and other central Africa Nations, resulting in a huge inflow of human traffic. It is a cosmopolitan town and an area of tourist attraction due to its geographical features. The majority of the population is involved in subsistence and commercial agriculture, energy generation, small-scale trade, dairy farming, flower farming, and commercial enterprises. Naivasha also plays host to people from different ethnic communities. It has three County hospitals, three Sub-County hospitals, 115 dispensaries, 43 health centers, and other private health facilities. Naivasha County hospital is one of the County level five health facilities in this county.

The two Counties were selected given their proximity to Nairobi County, where I was based at the time of conceptualization of this study. In addition, I had previously worked with the County Health Management Teams (CHMTs) in the two health facilities as part of my day-to-day support towards a strengthened GBV response in the two counties. I, therefore, considered the two sites due to the limited cost implication during data collection, and this also enabled buy-in from the teams. Furthermore, the two counties were among the first three counties where the first integrated post rape care service delivery model was launched in Kenya in 2005 by LVCT Health in collaboration with the Ministry of Health (Kilonzo, 2003; 2007).

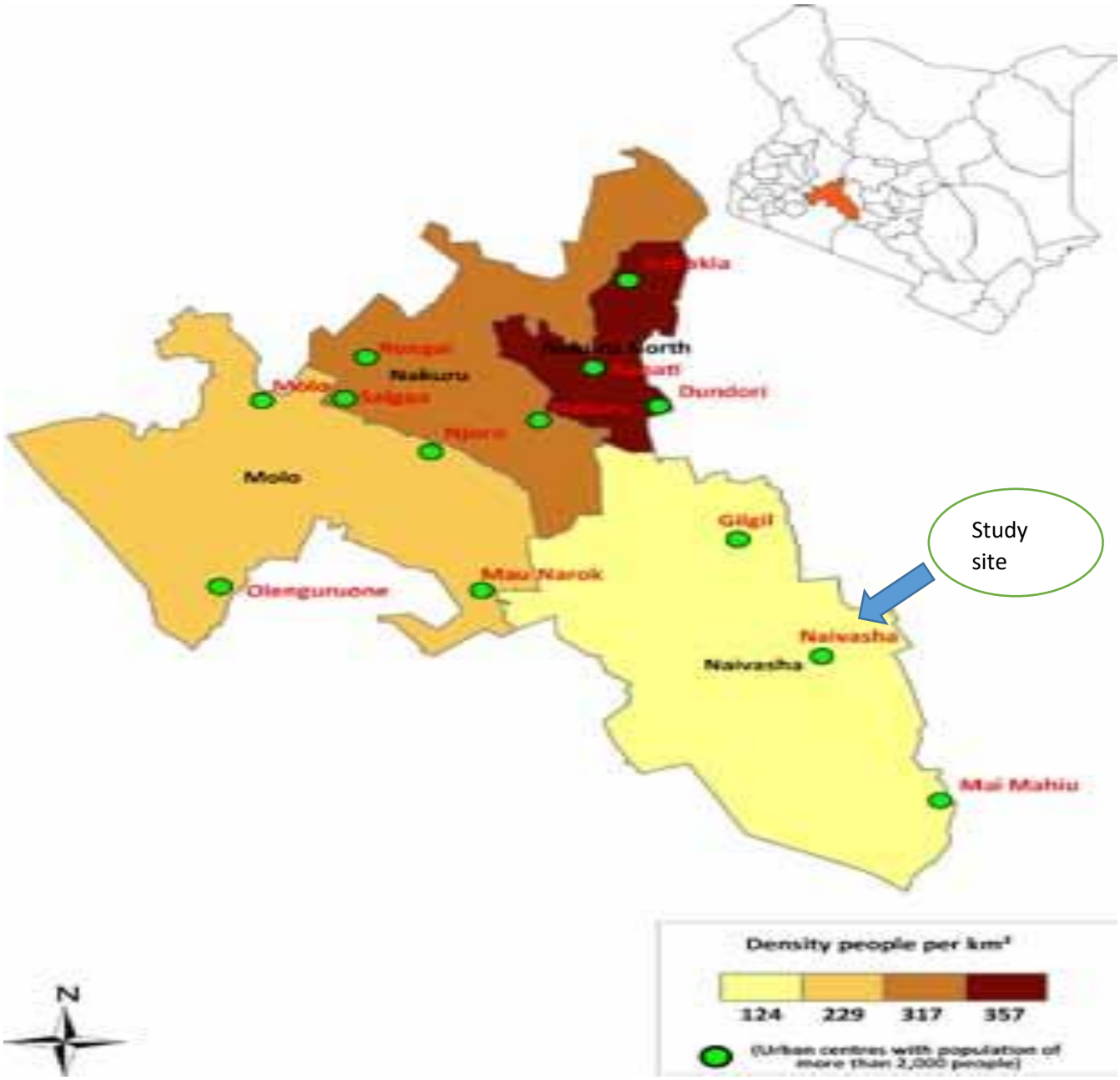


Figure 6: Nakuru county

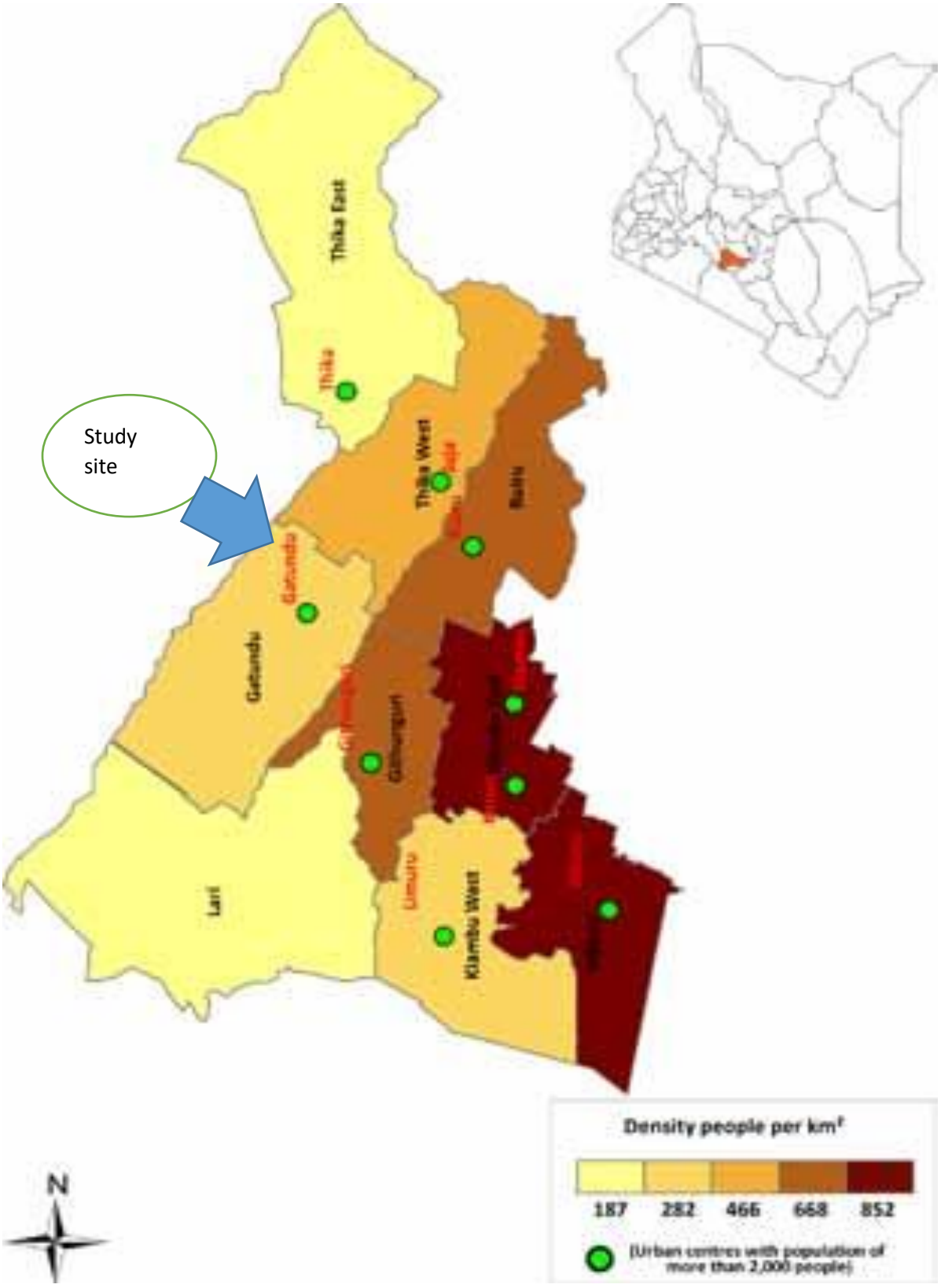


Figure 7:Kiambu county

ii) Study sites

This study was implemented in two County-level five hospitals (Naivasha and Gatundu County hospitals), two law courts (Naivasha and Gatundu law courts), and two police stations (Naivasha and Gatundu police stations). Also reached were shelters for vulnerable children within the study catchment area. This was critical in order to ensure a holistic understanding of the multi-sectoral care accorded to survivors within the same catchment area. The subsequent sections provide a detailed description of each of the study sites.

a) Health facilities

Health facilities in Kenya are classified into six tiers (Level 1-6). Each health strata offer a defined package of services. Level one constitutes of community services; level two, dispensaries and clinics; level three, health centers and maternity and nursing homes; level four, sub-County hospitals; level five, County referral hospitals; and level six, national referral and teaching hospitals

This study was undertaken in two (2) government health facilities which fall under level five-county referral hospitals (i.e. county referral hospitals), that offer standard comprehensive PRC. The standard PRC package, according to the Kenya National Guidelines entails the availability of trained PRC healthcare providers, who engage in history taking, forensic examination, evidence collection and documentation processes. =It also constitutes a trained trauma counsellor and a laboratory that can carry out HIV, hemoglobin, liver function, creatinine, and pregnancy tests (Ministry of Health, 2016).

The two health facilities included in this study were:

Naivasha County-level five referral hospital: It is located in Nakuru County, and it's a Level five facility in accordance with the health structure. The hospital serves a population of about 546,978 drawn from Naivasha town and its environs. The hospital is accessible mainly by road and serves patients from all walks of life. It offers PRC services, emergency first aid services, counselling HIV care and treatment, reproductive and maternal health services, community integrated management of childhood illness, physiotherapy, occupational therapy, tuberculosis diagnosis and management, laboratory, X-ray and inpatient services. The facility has a bed capacity of 247. It operates 24 hours; seven days a week. Naivasha County Hospital began offering PRC services in 2005 and the facility records attendance of approximately 177 survivors in a year. It provides comprehensive PRC services offered by Medical Officers, Clinical Officers, Nurses, Laboratory Technologists, Pharmacists and Counsellors.

Gatundu County-level five referral hospital: It is located in Kiambu County, 70km from Nairobi, and serves a population of about 423,000 drawn from Gatundu and its environs. The hospital is accessible mainly by road and serves patients with all manner of medical needs. It is a Level five facility in accordance with the health structure. Patients, including survivors of sexual violence access this facility mostly by use of public means of transport which include motor vehicles and or motorcycles. The hospital has a 162-bed capacity. The facility offers similar clinical, psychosocial, medico-legal services to those in Naivasha County hospital. It operates 24 hours, seven days a week. Comprehensive Post-Rape Care (PRC) services have been available in this facility since 2007, and it records attendance of approximately 65 survivors annually. These services are offered by Medical Officers, Clinical Officers, Nurses, Laboratory Technologists, Pharmacists and Counsellors.

b) Police stations

In Kenya, a rape incident is considered a crime against the State. The police are required in law to investigate all criminal cases of sexual violence reported to them. In the context of sexual violence, the police are mandated to act in accordance with the Sexual Offences Act, 2006 (Government of Kenya, 2006b) to investigate cases reported to them, prepare case files and charge the perpetrators in court. In terms of documentary evidence for cases of sexual violence, the police record all sexual violence-related complaints reported at police stations in the occurrence book. They also issue survivors with a P3 form which is a legally authorized medical form and accompany the survivors to the hospital for purposes of obtaining the required evidence that is collected by the health care providers. The police officers likewise play a key role in transferring forensic evidence to the national Government chemist for any additional analysis required. Two police stations, namely Naivasha Central and Gatundu police stations located within a radius of less than 20 km from the two facilities were purposively sampled for this study. Most survivors attended to in the two health facilities sampled for this study get referred to the sampled police stations to lodge sexual violence-related complaints in addition to being issued with a P3 form to be filled in by a medical provider.

c) Law courts

Two law courts in close proximity to the police stations were sampled. They included the Naivasha Principal and Gatundu resident magistrates' courts. In Kenya, the judiciary is tasked with a key role in upholding the provisions of the Constitution of Kenya, safeguarding the rights of the abused persons and ensuring accountability for all human rights violations. The law courts play a key role in the adjudication of all criminal cases, including those relating

to sexual violence. According to the Sexual Offences Act, determination of cases of sexual violence rests with the judiciary.

d) Shelters

Two shelters – Shelter A in Naivasha and Shelter B in Gatundu (names withheld due to the safety of the client's resident at these institutions) were included in this study. According to the National Gender and Equality Commission, shelters play a key multi-sectoral role in the provision of safety nets to survivors at risk of further violation from perpetrators. They provide a temporary holding for survivors in need of safety by offering an environment with an assurance of physical and emotional safety to survivors of sexual violence with the absence of trauma, violence, abuse and stress (Government of Kenya,2014). They manage survivors of sexual violence by offering social support, counselling, skills development, and rehabilitation services to survivors as well as linking survivors to other comprehensive PRC services such as medico-legal services. In most instances, child survivors abused by persons well known to them often get referred to rescue centers in the course of treatment and judicial proceedings. Both shelters are accessible from both the sampled police stations and health facilities.

3.3. Study design and methodology

i) Study design

The study adopted a retrospective design for the quantitative study component and cross-sectional study design for the qualitative component. The latter allows the researcher to study a given population in their natural setting. The quantitative enquiry used records were obtained from survivors who accessed services in the study sites over a one-year period from 2013 to 2014. This timeline was chosen as it coincided with the time within which the

Ministry of Health disseminated the revised National Guidelines on management of sexual violence and data capture tools for sexual violence cases reported to health facilities.

Many studies that seek to understand health-seeking behavior and utilization of services have found these designs to be very beneficial (Babitsch et al., 2012; Von Lengerke et al., 2014; Gil and Choi, 2019). In the qualitative component, the selection of this design enabled the researcher to examine the determinants of utilization of services by child and adult survivors of sexual violence in two Counties in Kenya over a period, retrospectively. In the qualitative component, I used the Anderson Health utilization model as the conceptual framework guiding the inquiry of the health-seeking behavior of survivors within a specific time period. The use of a cross-sectional design for the qualitative component aimed to clearly outline the factors influencing service utilization to understand the predisposing, enabling, and need factors.

The key variables understudy in the quantitative enquiry were as outlined below:

Dependent variable: This entailed the presentation of survivors at the different service delivery points and the treatment and management that occurred.

Independent variables: These included factors associated with age, sex, type of sexual violence, and relationship with assailant.

In the qualitative component, the study explored the predisposing, enabling factors or hindering factors for utilizing service at various levels, as per the Anderson model (1995). The possible *predisposing factors* in this study were age, sex, marital status, and education, attitudes towards services and values towards seeking help. *Enabling factors* were resources available to the individual to facilitate access to services, e.g. time and money. *Needs factors*

revolved around an individual's own perception of their own health status and the need to seek help.

The following key questions underpinned the investigation in this study

a. What are the characteristics of sexual violence survivors?

b. How functional are the operations of the multisectoral chain of evidence and custody for management of sexual violence?

c. What are the enabling and hindering factors influencing sexual violence survivors attending and reporting to services?

d. What are the views of sexual violence survivors and members of the team providing sexual violence services on the manner the services are provided?

e. What are the current gaps and opportunities in the provision of comprehensive services to survivors of sexual violence in Kenya?

f. How can the current fragmented sectoral responses to sexual violence be addressed using a multi-sectoral referral and coordination framework?

ii) Study methodology

Mixed methods were applied in this study where the integration of qualitative and quantitative data within a single study is done in order to understand the research problem better (Adatho, 2011). The application of a mixed-methods approach provides room for a researcher, through a quantitative methodology, to also be able to quantify a given occurrence. Additionally, its functionality can be reviewed through a qualitative methodology to gain a deeper and contextual understanding of the study problem. This study employed

mixed data collection methods consisting of an analysis of records and in-depth interviews (Albright et al., 2013). The use of mixed methods also allowed for corroboration or triangulation of study results obtained using one approach to inform another approach, investigate a research problem from different angles and/or building on findings from one to the other approach. The study applied a concurrent mixed methods approach where both quantitative and qualitative data were obtained at the same point in time (Driscoll et al., 2007; Berger, 2018).

The quantitative study component established the number of survivors who accessed care and their characteristics. It, therefore, described those seeking care and those who were referred for various services. It was used to calculate and compare the number of survivors accessing services sampled in the two separate facilities. It also investigated the accuracy of data documentation as per the Kenyan Guidelines and the functionality of the multisectoral responses to sexual violence service provision. The study sought to understand how the referral of survivors occurs across different sectors and the coordination mechanisms in place. Quantitative data were abstracted from registers and case files maintained for survivors. It entailed a retrospective review of health facility, police station and judiciary records. These data were in the form of records for the period of June 2013 to June 2014. It determined the proportion of cases of sexual violence that had been attended by the three institutions, the services offered, and the type of referrals made by police and health facility

The qualitative approach, on the other hand, allowed the study to provide a context as to why certain conditions exist with a focus on the respondents' attitudes, values, and experiences on the study matter. Qualitative approaches are most appropriate in studies that explore gaps that cannot be quantified based on the dynamics revolving around the

participants' perceptions and beliefs on the issue under study. A qualitative component was therefore considered appropriate to provide a contextual basis to the underlying predisposing, and enabling factors exhibited by survivors of sexual violence and providers. Engaging survivors, caregivers and providers enabled me to gain insights into the contextual issues that contribute to survivors opting to report or not report their experiences. It also revealed o why they would choose to access services from one sector and not the other and helped make recommendations that are appropriate for the persons or contexts concerned (Ivey, 2012; Draper, 2004). Qualitative approaches also provide the researcher with room to interpret the findings in an effort to develop a holistic view of the subject matter (Brannen, 2017). In this study, a qualitative approach was used to enable a broad and deeper understanding of the service delivery and health-seeking behaviors from survivors and approaches to service delivery utilized by providers. It provided researchers with the opportunity to gain an in-depth understanding of this sensitive topic by interacting with a relatively small number of individuals who have experienced the abuse (Nardi, 2018). In addition, qualitative methods open room for the researcher to reflect on their thoughts and biases during the research process (Sutton and Austin, 2015).

Through the use of the mixed methods approach, it was necessary to employ triangulation of data in order to have a deeper understanding of the service utilization and provision in the context of sexual violence. The use of this additional and combined approach also facilitated a deep-dive into survivor experiences in the utilization of the PRC services in an effort to establish factors that inform their health-seeking behavior. The results and findings were integrated during interpretation.

3.4. Study population, sampling and recruitment procedures

The study population comprised providers drawn from different sectors involved in the provision of services to survivors, and records maintained for survivors by the different departments.

i) Qualitative study population and sampling frame:

Study population: In applying the Anderson Health model to this study, the study respondent population was selected based on the model presented in Chapter two to capture the various factors that contribute to health-seeking behavior. Hence this study chose a population that would help shed more insights on the experiences of survivors seeking care, caregivers offering support, providers involved in the management of survivors, and community members who shape what is considered acceptable (or not), and what seems like an appropriate health-seeking behavior. The study also sought to understand how the referral of survivors occurs across different sectors as well as the coordination mechanisms in place. To achieve this, the service providers from different sectors were drawn from the appropriate study population: police officers, health providers and magistrates from the sampled institutions. Health care providers and police officers constitute the first line of reporting for cases of sexual violence in Kenya (Shako and Kalsi, 2019b).

Service provider sample: In Kenya, various actors are involved in the provision of services. The sample for this study was drawn from various departments, as outlined in Table 2 below. The health workers were selected from the outpatient department, as well as laboratory and counselling departments within the health facility. For the other sectors, the in-charges were selected as participants. They included the police officers in charge of the gender desk, chief magistrates, children officers, a representative from one NGO involved in

the provision of support to survivors and in charge of the safe shelters. The selection of these service delivery points was informed by the National Guidelines on the management of sexual violence and the multisectoral standard operating procedures for sexual violence as entry points for survivors of sexual violence within the health, legal, and protection mechanisms (Ministry of Health, 2016; Kilonzo et al., 2009c). The selection of respondents across the above-mentioned departments was to help provide an in-depth understanding of the available services, referral pathways in place, and gaps in the response pathways. At the national level, interviews with policymakers from the National Gender and Equality Commission (NGEC), Taskforce on the Implementation of the Sexual Offences Act (TFSOA), Ministry of Health (MoH), and the Office of the President (where departments of Police, Youth, and Gender are located) were to be conducted, but this was not possible due to the challenges faced in obtaining permission to secure interviews with relevant persons.

A total of 23 respondents were involved in the management or determination of cases of sexual violence. They include three survivors of sexual violence and two guardians. Service providers involved in the provision of PRC services were 12 health care providers, two police officers, two magistrates, two Shelter managers and two children officers. The above respondents in the context of this study were considered better placed to provide an in-depth understanding of the utilization of services by survivors. The emphasis was on the factors outlined in the Anderson Health Model. They are: (1) what predisposes survivors to report (or not report) cases of sexual violence, (2) the underlying needs presented by survivors and whether the current service delivery models are responsive to these needs, (3) the enabling factors towards the achievement of multi-sectoral referral pathways and linkages. Survivors of sexual violence presenting for care during the data collection at the two health facilities were purposively selected for inclusion in the study. Their inclusion was to

enable them to share their experiences and perceptions during their interaction with the different sectors. In addition, stakeholders drawn from the children's department, rescue centers and NGOs were purposively selected to provide insights on the survivor referral mechanisms in place.

Method of Service provider sampling: Purposive sampling and snowballing approaches were utilized in this study to ensure the inclusion of respondents with rich information (Patton, 1990). Purposive sampling is commonly used in qualitative data collection to ensure that the respondents are selected based on their knowledge of the study topic. This sampling strategy is a method that is mostly used to aid in the identification of a research sample in studies that deal with sensitive topics (Velzeboer et al., 2003). Purposive sampling is usually employed when the targeted respondents have knowledge that is useful in addressing the study questions. In this study, a respondent was considered to have rich knowledge on the topic of study if they had worked in that department for more than a month or were seconded by management as the most appropriate persons to be considered for the study. The use of this sampling strategy made it possible for me to include a broad range of providers with experience in attending to survivors of sexual violence. For this study, I identified through the departmental heads in the health facility, police stations, courts, community and children's department key staff who were directly involved in the management of survivors, and/or those who had been trained on PRC service delivery through various stakeholders. Thereafter, I identified additional potential respondents through snowballing. This corroborates the position made by Bryman (2012) on the application of snowballing after use of any other purposive sampling approach. When using the snowballing sampling method, respondents themselves suggest other individuals who or groups which can be recruited (Collumbien et al., 2012). In this study, I reached out to the

initial contacts received at each service delivery area to identify and reach out to other potential participants knowledgeable on the subject matter.

Service provider recruitment: The recruitment of providers was carried out upon consultation with the departmental heads due to the nature of the interviews that were conducted during service delivery hours. The involvement of the department heads was to ensure that providers were relieved of the service delivery duties so as not to interfere with their ability to offer services, with other service providers being seconded by the management to support service delivery during the interview sessions. This was done to avoid inconvenience on service provision. At least two front line providers and one management representative each from the health, police, judiciary, children's department, and rescue centers, in the two study sites, were added in addition to representatives from two NGOs based in Nairobi.

Survivors of sexual violence (guardians) sample: In this investigation, it was not possible to draw up a sample of survivors who would be recruited into the study. Therefore, all survivors of sexual violence (or their guardians) who presented at the selected health facilities during the study implementation process were sampled and upon consent recruited into the study. Their inclusion was to help provide their perspectives on the services received and the referral pathways. Survivors were also sampled after they had accessed all services in the facility so as to help shed more light on their experiences in navigating through the health sector. For survivors aged below the age of consent (which is 18 years in Kenya), their guardians were the ones who were instead recruited into the study.

Method of sampling of survivors of sexual violence: A snowballing approach was also employed, where providers helped in identifying and linking survivors to the researcher. Only

those survivors of sexual violence (or their guardians) who reported for post rape care at the selected health facilities during the study implementation process and consented to be interviewed were recruited into the study. This was to obtain feedback on how the referral process was undertaken. The survivors were linked to the research assistant by the health care provider who attended to them after they had received the required medical attention. The research assistant obtained consent from the survivors or guardians prior to their participation in the study. Table 2 below outlines the respondents who were recruited into the study.

Table 2: Number of respondents interviewed

Type of institution	Person interviewed	#s interviewed by County	
County		Naivasha	Gatundu
Hospital	Clinical officer	1	2
	Trauma counsellor	1	1
	Social worker	1	1
	Survivors	3	0
	Guardian	0	2
Police station	Police office gender desk	1	1
Court	Magistrate	1	1
Children Office	Children officer	1	1
Shelter	Manager or person in charge	1	2
National level			
NGO	Executive Directors (National)	2	
	Total # of persons interviewed	23	

ii) Quantitative sample

Records sample: All records maintained for survivors in the sampled health facilities, police stations and law courts for the period June 2013 to June 2014 were obtained and included in the study. The records included PRC form, laboratory registers, counselling registers, PRC register, P3 forms, and court registers. The sampling of all PRC forms filled in

for prospective survivors of sexual violence presenting at the health facilities over a 12-month period from the commencement of the study was undertaken. Also sampled were records maintained for all cases of sexual violence at the courts and police station. Altogether, 1334 records were selected, and 1259 were included in the analysis, as outlined in Figure 8 below. The 75 records that were excluded had missing entries and could therefore not be linked across the different service points or conclusively associated with sexual violence, especially given that the registers were also utilized in the health facilities to document other forms of GBV reported.

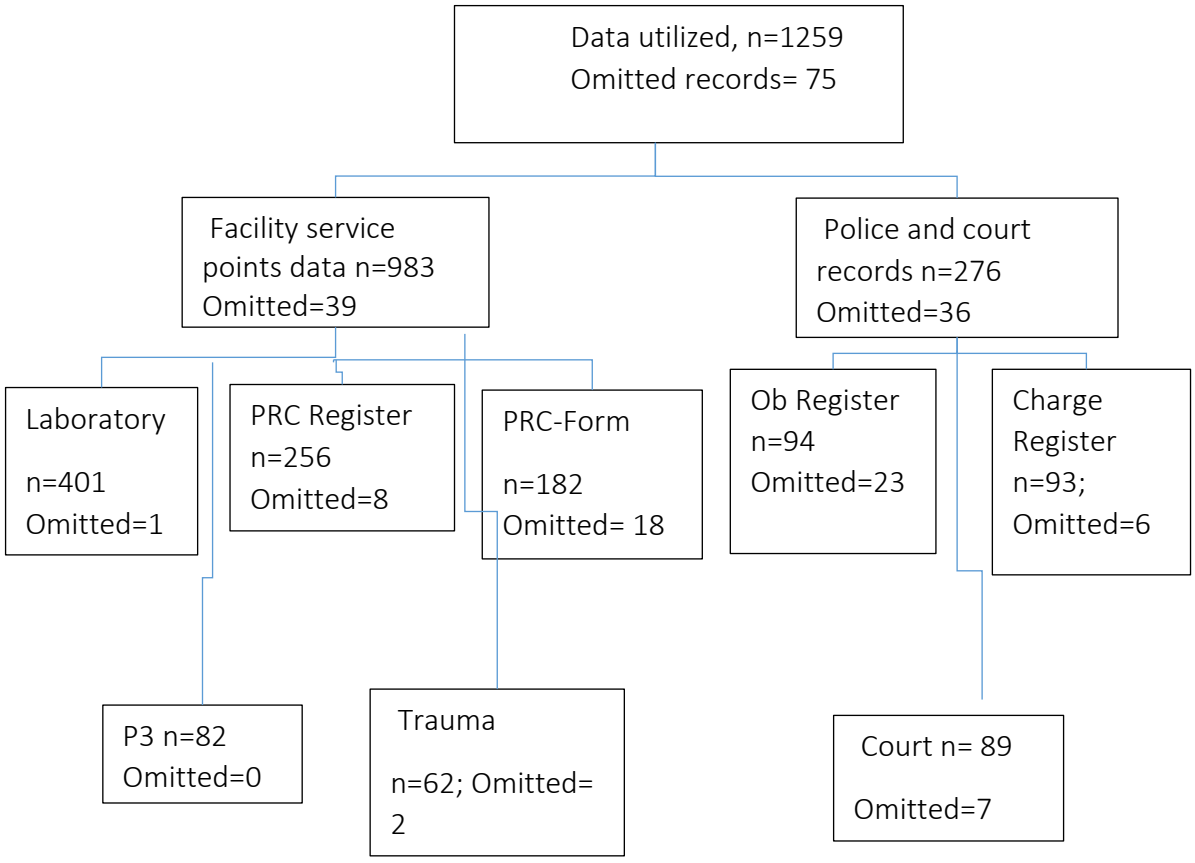


Figure 8: Records reviewed from different data sources (June 2013-June 2014)

3.5. Data collection approaches

i) Qualitative data collection

The interviews were conducted by the Principal Investigator with support from a trained research assistant who was conversant with the two national languages in addition to the local dialect commonly used in the targeted counties. This was to help capture the meaning behind any *Kikuyu* words mentioned in the interviews. We used a semi-structured interview guide. The focus was placed on determining whether survivors report for care within 72 hours, adhere to treatment and uptake follow up as given from the different sectors.

The interviews were conducted in private offices identified by the respondents within the work environments. Informed verbal consent was obtained from the respondents. Verbal parental consent was obtained for survivors aged below 18 years. Verbal consent was considered appropriate due to the anticipated low levels of literacy among survivors, given the settings where this study was conducted. The use of verbal consent also mitigated any fears providers, and caregivers would have with regards to writing down their names on a form. All interview sessions were audio-recorded. On average, each interview lasted 45 minutes.

The demographics of survivors of sexual violence accessing services were also captured. In addition, the study assessed the enabling and hindering factors to service utilization. I explored the various institutions involved in the management of sexual violence, survivor perception to post sexual violence services received, and referral mechanisms in place. Through a review of literature, I had already established the PRC package of care available to survivors, roles of the different sectors, national data capture tools in use, referral mechanisms in place and uptake of referrals across two counties.

ii) Quantitative data collection

Quantitative data collection entailed a review of PRC service delivery data from the hospitals, police stations and law courts to establish the type of sexual violence-related complaints reported. These are like: socio-demographic information of the survivors, type of services offered, and referrals made. Quantitative data were abstracted from registers and case files maintained for survivors, and it involved a retrospective review of health facility, police station and judiciary records. These data were collected through the use of standardized abstraction tool (Appendix 6) with the aim of determining the number of cases of sexual violence that had been attended by the three institutions, services offered, and type of referrals made by police and health facility. The research assistant obtained original copies of the survivor's records at each service delivery point. Data extracted from the registers was directly entered into an excel spreadsheet by a research assistant with prior experience in review and abstraction of sexual violence data for programmatic purposes. Missing entries in the registers and PRC forms were also noted.

The data collected from the different service delivery points included:

- Facility Outpatient Department: Data was abstracted from the PRC Registers and PRC forms. The review established number of survivors attended to, name of the survivor, date when the survivor reported to the hospital, and where the survivor was referred to. The data was manually transferred to a data abstraction form developed in excel.
- Laboratory: The data captured from the laboratory register included the survivor's demographic information (name, sex, and age), the origin of referral and laboratory tests that were conducted.

- Trauma counselling department: From this service delivery point, this study focused on the number of survivors who had been counselled and the service delivery point they had been referred from.

- Police records were captured from the occurrence book register (OB Register), and case registers for all the cases pending before the court. Data collected included date and time when the case was reported, name and age of the complainant, type of the offence (defilement or rape), where the survivor was referred to, as well as the name and age of the perpetrator.

- Court records: This data was obtained from the court registry. The review focused on sexual violence cases filed before the courts from June 2013 to June 2014. Using the case file numbers, the following information was retrieved from the charge sheet: - Date when the case was filed, name of the accused, age, sex, name of the survivor, date of the assault, type of assault (defilement, rape, attempted rape, attempted defilement), and stage of the proceeding. (for example, whether a case was ongoing/pending, withdrawn, or had been concluded).

Table 3 below provides a summary of data type captured and the sources of data

Table 3: Data collected by type of tool

Research question	Data type	Targeted respondents	Data sources
Uptake of services from different sectors • The number of survivors of sexual violence attended and received post rape care at the health facility, police station, legal aid centers, and community-based organizations? • Service Offered by each sector • Type of information obtained from survivors	Institutional records (PRC form, and registers)	Survivors	Key informants and Records **(Appendix 4- Tool 2 and 4)**
The first point of reporting: • Type of services they received at the first point of reporting by age • What informed their choice on where to report first?	Interviews and Record reviews	Survivors (guardians)	Institutional Records **(Appendix 4- Tool 1 and 4)**
Referral pathways from the first point of reporting • What referrals were they given from the first point of reporting? • Why they were referred • Where were they referred? • Were the survivors asked to indicate where they prefer being referred to for further care? • Did the referral match the needs presented by the survivor?	Records and In-depth interviews	Survivors and service providers	Records and Key informants **(Appendix 4- Tool 1, 2 and 4)**
Referral uptake: • Did they use/attend these referrals? • What was the distance (in time) between the different referral points? • Are survivors accompanied to the referral point?	In-depth interviews	Survivors and service providers	Records and Key informants **(Appendix 4- Tool 2 and 4)**
How do the different sectors coordinate/link up with each other in the provision of PRC services? • What document was used in documenting care received upon reporting and during referral? • Existence of indicators that can be shared across different sectors to enhance the delivery of comprehensive services • What mechanisms are in place to facilitate joint meetings between stakeholders from different sectors to discuss how to strengthen the response to sexual violence • What measures are required at national and County level to address the existing fragmented sexual violence response • Role of the existing national bodies with a focus on strengthening the coordinated response to sexual violence	Program staff, Managers and Policymakers	Policymakers , In- charges of children's homes, and NGOs	Key informants **(Appendix 4-** **Tool 3)**

b) Pilot study and training

Piloting of the data tools was undertaken in Nairobi prior to data collection exercise to help assess the flow of the questions and respondents understanding of the questions asked. The piloting was undertaken using a research assistant engaged by a Kenyan organization, LVCT Health, to support the sexual violence programme. Data was collected from LVCT Health providers involved in the management of survivors of sexual violence. During piloting, it was established that there was no need to translate the tools into Kiswahili or the local dialect as the research assistant was conversant with all the three languages.

I conducted a one-day sensitization training of the research assistant with a focus on study objectives; County engagement procedures; ethical considerations to be observed; an overview of the data expected for each of the questions; and interviewing skills required.

Prior to the commencement of the fieldwork, I accompanied the research assistant to the two Counties and wrote a letter introducing her to the targeted institutions. I also handled all the logistics of the fieldwork with a focus on setting up meetings with the different institution heads to introduce the study and plan on when the interviews would be carried out. Weekly planning had to be done to ensure systematic collection of data per County, and with minimal disruption to normal service delivery.

I held four meetings with the research assistant during the data collection period to review the quality of data to address any logistical challenges and provide feedback on the interviews conducted in the course of the week so as to determine questions that needed further probing. In these meetings, I also reviewed the copies of records that had been made to assess the quality and completeness of the data captured. In the event that records were

found to be unclear, the research assistant visited the concerned health facility to collect data on the missing information.

3.6. Data management and analysis

Quantitative data were entered into SPSS Version 20.0, and the analysis carried out with the assistance of a statistician. Prior to the analysis, data were cleaned to assess completeness and accuracy. Where an error was observed, corrections were made by revisiting the raw data. Descriptive statistics for records was obtained. Chi-square was computed to compare the outcomes between the two counties and select variables of the study. Binary logistic regression analysis was used to determine the factors influencing sexual violence and health services uptake by the survivors.

Qualitative data were transcribed by three assistants, while analysis of the transcripts was undertaken by me as guided by the study objectives using NVivo 10 – a qualitative analysis software. Following fieldwork and transcription of all recorded data, all 23 transcripts were analyzed with the use of NVivo 12 software. A thematic analysis was undertaken as described by Braun and Clarke (Braun and Clarke, 2006): (1) familiarizing oneself with data; (2) generating initial codes across the data set; (3) identifying themes by collating identified codes into themes and gathering data that was relevant to each theme; (4) reviewing themes; (5) defining and naming themes, and (6) generating the analysis report. I coded the transcripts. The thematic analysis approach provides researchers with the opportunity to generate a thematic description of the data by bringing forth the dominant themes to guide the coding and analysis of the data in line with the study objectives (Aronson, 1995). Themes are generated to help make sense of the data that would otherwise be “meaningless” when

viewed in isolation (Leininger, 1985). In this study, the thematic coding of the study transcripts was undertaken by me.

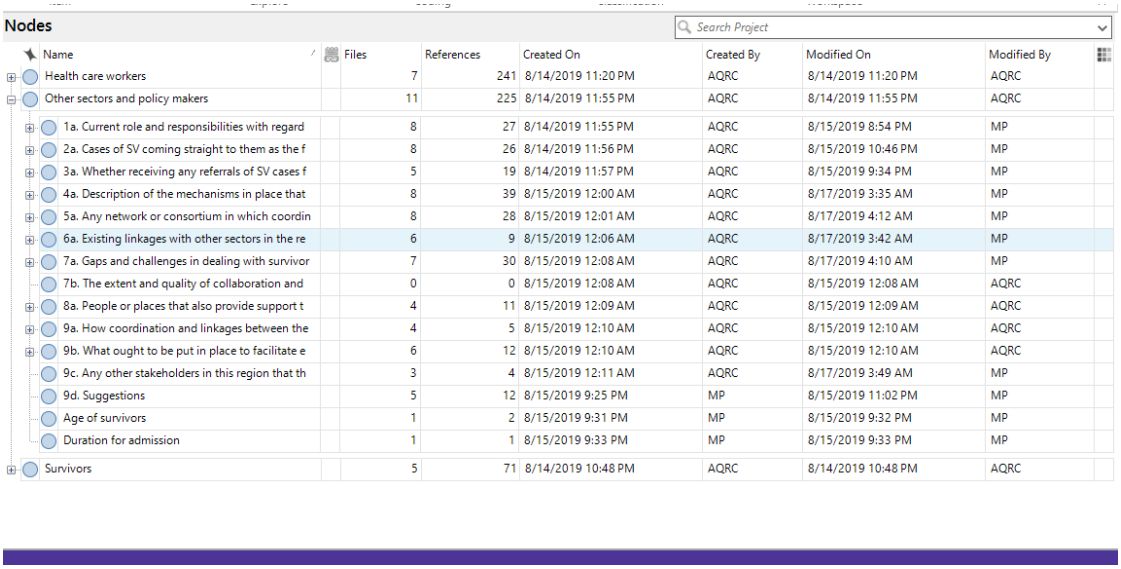
Familiarization of the data was undertaken by a researcher and myself. This stage involved reading through the transcribed data to make sense of the data. Through a deductive approach, the main themes that emerged from the interviews were drawn as informed by the study objectives and the Anderson (1973) Framework. The aim of this was to inform key themes to produce an initial coding framework, which was revised in the course of the analysis. Thereafter, I imported the data to NVivo 10 and generated an initial coding framework based on the emerging themes and sub-themes for each respondent category resulting in a codebook to group the data accordingly (Sample codebook- Table 4 below) (Ryan and Bernard, 2000).

Data were analyzed thematically using a deductive approach. I noted down emerging concepts from the transcripts and developed the themes. I used two interviews per respondent category to undertake the initial code development and used this to update the coding framework. To improve the validity of the coding process, I engaged a qualitative researcher (PN) to improve the reliability of the framework. PN did an independent review of the transcripts and developed her thoughts on the themes without referring to the framework I initially developed. There was a consensus between the two of us around the major themes and sub-themes. PN collapsed the two individual coding frameworks into one version, read through and coded the rest of the transcripts. Finally, I utilized the coded data to derive meaning from the data.

Table 4: Sample of the study codebook

Name	Description	Files	References
Health care workers	Interviews for health care workers	7	241
1a. Survivors of sexual violence	No. of survivors of sexual violence received post rape care services over the last six months	7	7
2a. Services to survivors of sexual violence in the facility	-This includes services that are offered to the sexual violence survivors at different departments within the facility	7	28
Medical treatment	This includes the laboratory tests and issue of drugs	3	4
Physical examination	The examination of the survivor's part of the body that was affected to assess the extent of damage and verify a sexual violation	4	4
Preventive care services	This includes the administration of preventive drugs such as PEP for HIV and pregnancy prevention	5	5
Referral to other departments	This is both within the facility and outside the facility	4	5

Thereafter, I grouped the textual data into the relevant parent code and generated child nodes as appropriate. Figure 9 below provides a sample of the coding outlook generated through this process.



Nodes

Search Project

Name	Files	References	Created On	Created By	Modified On	Modified By
Health care workers	7	241	8/14/2019 11:20 PM	AQRC	8/14/2019 11:20 PM	AQRC
Other sectors and policy makers	11	225	8/14/2019 11:55 PM	AQRC	8/14/2019 11:55 PM	AQRC
1a. Current role and responsibilities with regard	8	27	8/14/2019 11:55 PM	AQRC	8/15/2019 8:54 PM	MP
2a. Cases of SV coming straight to them as the f	8	26	8/14/2019 11:56 PM	AQRC	8/15/2019 10:46 PM	MP
3a. Whether receiving any referrals of SV cases f	5	19	8/14/2019 11:57 PM	AQRC	8/15/2019 9:34 PM	MP
4a. Description of the mechanisms in place that	8	39	8/15/2019 12:00 AM	AQRC	8/17/2019 3:35 AM	MP
5a. Any network or consortium in which coordin	8	28	8/15/2019 12:01 AM	AQRC	8/17/2019 4:12 AM	MP
6a. Existing linkages with other sectors in the re	6	9	8/15/2019 12:06 AM	AQRC	8/17/2019 3:42 AM	MP
7a. Gaps and challenges in dealing with survivor	7	30	8/15/2019 12:08 AM	AQRC	8/17/2019 4:10 AM	MP
7b. The extent and quality of collaboration and	0	0	8/15/2019 12:08 AM	AQRC	8/15/2019 12:08 AM	AQRC
8a. People or places that also provide support t	4	11	8/15/2019 12:09 AM	AQRC	8/15/2019 12:09 AM	AQRC
9a. How coordination and linkages between the	4	5	8/15/2019 12:10 AM	AQRC	8/15/2019 12:10 AM	AQRC
9b. What ought to be put in place to facilitate e	6	12	8/15/2019 12:10 AM	AQRC	8/15/2019 12:10 AM	AQRC
9c. Any other stakeholders in this region that th	3	4	8/15/2019 12:11 AM	AQRC	8/17/2019 3:49 AM	MP
9d. Suggestions	5	12	8/15/2019 9:25 PM	MP	8/15/2019 11:02 PM	MP
Age of survivors	1	2	8/15/2019 9:31 PM	MP	8/15/2019 9:32 PM	MP
Duration for admission	1	1	8/15/2019 9:33 PM	MP	8/15/2019 9:33 PM	MP
Survivors	5	71	8/14/2019 10:48 PM	AQRC	8/14/2019 10:48 PM	AQRC

Figure 9: Sample coding output

The analysis was thereafter undertaken to tease out any key issues emerging, similarities and differences in the type of responses made. An inductive analysis of the emerging issues was undertaken to establish areas of convergence and divergences from the data. A chart of data set to show the intensity of the codes per theme was undertaken (Boyatzis, 1998). A sample is illustrated in Table 5 below

Table 5: Example of charting

	Health care workers						Other stakeholders												Survivors			Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	
Health care workers	x	x	x	x			x	x						x								7
Services provided to survivors of sexual violence in the facility	x	x	x	x			x	x						x								7
Counselling			x	x			x	x						x								5
Medical Treatment	x	x						x														3
Physical examination	x		x				x							x								4
Post-trauma counselling		x																				1
Preventive care services		x	x	x			x	x														5
Referral to other departments	x	x		x										x								4

3.7. Reflexivity and Trustworthiness of data (qualitative)

Reflexivity: Qualitative research calls for a researcher to reflect on how the data generated through the study might be affected by their own biases and decisions across the different stages of study design, data collection and analysis (Glesne, 2006). Reflexivity is considered as a process that entails, "critically inspecting the entire research process including reflecting on the ways in which the fieldworker establishes a social network of informants and participants in a study; and for examining one's personal and theoretical commitments to see how they serve as resources for generating particular data, for behaving in particular ways vis-à-vis respondents and participants, and for developing particular interpretations" (Schwandt, 2007). In qualitative studies, the researcher is counted as a research instrument, and their

positionality on the theme of study influences their choices and approaches. I, therefore, selected this study topic based on my role in implementing PRC health initiatives rolled out in the organization I was working for (LVCT Health). Notable during this study was that while national policy documents and legal frameworks governing PRC had been developed and disseminated nationwide, gaps exist in so far as referral mechanisms of survivors was concerned. This informed my selection of the study topic as well as the health facility and police station as my point of reference for referral mechanisms. I sought to focus on understanding what is currently being done in these two sectors to facilitate survivor access to comprehensive services. Having contributed to the development of the national sexual violence multisectoral SOPs which outline the importance of a coordinated sexual violence response, I opted to carry out this study so at to help inform the improvement of the referral mechanisms. In undertaking this study, I put myself in the shoes of providers who had been trained on management of survivors yet failed to provide a comprehensive and coordinated response with the aim of understanding the systemic barriers towards this. The quality of care was also measured against a client's experience with the care provided to him/her. In line with this, I sought to obtain information from survivors (and their guardians) on their experiences in seeking care and taking up the referrals made. These understandings played a significant role in my selection of a qualitative methodology to gain an in-depth understanding of the service delivery, referral approaches, and survivors' perspectives of the same. I had an opportunity of attending the full course on the clinical management and trauma counselling of survivors of sexual violence. It is through these courses that I came to comprehend the importance of how documentation of services offered is key in decision making and determination of the comprehensiveness of services given. Hence the reason why I included

a record review component in my study methodology. My engagement with health care providers and police officers during my routine work also influenced my selection of sites with already established PRC services, and identification of the service delivery departments and respondents to be reached through this study.

In order to avoid providers feeling obligated to participate in this study due to my role in leading LVCT Health's PRC interventions in the study sites, I opted to have a trained research assistant familiar with the PRC service delivery and data tools to undertake the data collection on my behalf. The involvement of the assistant was also key to helping avoid expectations of compensation by the providers who had agreed to participate in this study. The practice of compensating providers for time spent in engaging in studies was initiated by LVCT Health, had been inculcated in providers from the selected sites.

However, my active involvement at the national level through the Reproductive Health Technical Working Group (RHTWG) and my association with LVCT Health made it possible for me to get study authorization and approval letters from the national RH TWG and County level departments of health, education and the police with no difficulty.

The trustworthiness of the data: This study was framed on Guba's criteria for ensuring trustworthiness in qualitative research. The criteria include credibility, transferability, and confirmability (Guba, 1981, pp. 75-91). I undertook several measures to ensure both the trustworthiness of the data collected and processes undertaken. The study used interview guides and questions were framed while keeping in mind the sensitivity of the subject. Individual

interview sessions were held with the respondent to help prevent any discomfort among the respondents.

In order to attain the credibility of the data, the study triangulated data obtained through both quantitative and qualitative data collection approaches. The use of different data collection methods has been demonstrated to enhance the credibility of the data given by compensating the cons associated with the different methods and avoid any researcher biases (Brewer and Hunter, 1989; Golafshani, 2003). Site triangulation was also undertaken as a measure to enhance credibility by establishing whether similar results would be obtained from different sites. The study also recruited providers discharging similar roles but located in different counties and institutions to help attain some level of generalizability of the data obtained on services provided and referral mechanisms utilized. The data collection was conducted by an experienced research assistant with vast knowledge on the subject matter and experience in undertaking sexual violence-related research, who was also trained in the study processes to be applied.

3.8. Validity of data (quantitative)

Validity in quantitative research refers to measures put in place to ensure the accuracy of the data being collected (Heale and Twycross, 2015). Given the sensitivity of the study topic and the need for the validity of the data collected, all the interview sessions were conducted in an environment that guaranteed privacy. Respondents were assured of the confidentiality measures that had been put in place to enhance the anonymity of the data records. Content

validity of the quantitative data was enhanced by ensuring the variables contained in the data abstraction tools were drawn from the PRC data tools, without making any modification.

3.9. Ethical considerations

Sexual Violence is a traumatic event which can adversely affect the survivor. Although this study did not introduce any procedures outside the recommended management of sexual violence within the facility, there are potential physiological and psychosocial risks associated with management of sexual violence. This study, therefore, applied the World Health Organization (WHO) guidelines on ethics and safety of conducting studies on Violence Against Women (VAW). Various measures were put in place to safeguard the rights of the respondents and data retrieved from the institutional records. These are outlined below:

Ethical approval: Ethical permission was granted by the University of Cape Town's Health Sciences Faculty ethics committee and National Council for Science and Technology (NACOSTI) in Kenya. In addition, approval for the study was also obtained from the relevant County Officers in the selected study sites. In addition, I undertook the following to minimize any risks to participants:

Data collection approval processes: The study was conceptualized before the introduction of the devolved system of governance in Kenya. This necessitated engagement with the Reproductive Health and Maternal Services Unit (RHMSU) of the Ministry of Health (MoH). This Unit is mandated with setting priorities for Reproductive Health (RH) Gender-Based Violence (GBV) related research and programmes at the National level of Government. Approval to carry on with my study was obtained from the Head of the RHMSU Gender Program in 2013. To be

able to collect data from the sampled health facilities, police stations, and courts, I had to obtain approval from the County Commissioners', and County Executive Ministers of Education and Health in Kiambu and Nakuru Counties. Upon receipt of study implementation and approval from the Ministry of Health, I established that one of the health facilities sampled, namely Thika County Hospital in Kiambu County had instituted new regulations requiring that all students and organizations with the intention of collecting data from this facility to seek fresh ethical approval from the hospital ethics committee. This, in my view, would delay the commencement of my data collection. Upon discussions with my supervisor, I identified another health facility, Gatundu County Hospital from the same county with similar characteristics as Thika County Hospital. This facility attends to survivors of sexual violence and has providers trained on management of survivors. I, therefore, replaced Thika County hospital with Gatundu County hospital as a study site. Consequently, I had to obtain fresh approval letters from Kiambu County commissioners to commence data collection in Gatundu.

I met with the respective In-Charges of the sampled facilities prior to data collection to brief them on my study objectives. I also received permission to interview providers and review records. In order to obtain records from Gatundu Law courts, I had to get approval from the Chief Registrar of the Kenyan judiciary. I did not experience any challenges in collecting records from the Naivasha Law Courts.

Ethical considerations during data collection: This study utilized support from a research assistant who had undergone intensive training on research on VAW conducted by LVCT Health. However, prior to the commencement of the study, I briefed her on the consenting processes,

referral pathways for survivors in distress, and how to terminate interviews in instances where the respondents experienced any form of distress. The study participants were briefed on informed consent, measures that would be put in place to safeguard their information.

Informed consent: Participating in this study was voluntary. All participants recruited into the study were briefed on the objectives, and a request for their participation in the study made. A standardized information sheet was used, which explained the study objectives and the right of respondents to withdraw from the study at any time or decline to answer any question. Consent to audio-record the session was also obtained. Use of tape-recorders was also made possible through the consenting procedures. The research assistant also indicated to the respondents that any unwillingness to participate in the study would not be used as a punitive measure against them. Only participants who agreed to participate were taken through the informed consenting process after which verbal consent was obtained. The informed consent also entailed briefing the participants on the expected outcomes and how the findings would be utilized to strengthen PRC service delivery in Kenya.

Confidentiality: Protection and confidentiality of the respondents and data were ensured by conducting the interviews in private settings, maintaining the confidentiality of the audio files, transcripts and abstracted data through the use of codes to de-identify the data collected. Participants were not to be identified by their real names on study instruments but by a study code unique to them. For purposes of tracking the participants' records from the hospital system and follow-up, the study code was generated to trace participants' names through the various health facility records. Access to study records and computers was restricted to study personnel.

Computer database containing participants' information was only accessible to me as the Principal Investigator (PI) as well as the statistician.

Safeguarding survivors: Adult caregivers of child survivors were required to give consent before enrolment of a child into the study. The interviews were then conducted in a simple language that the children and their guardians/parents could understand. These interviews were also done after the survivor had attended all the services at the health facility. A psychological counsellor with experience in handling survivors was identified in every facility to provide any additional counselling to the survivors as deemed necessary.

The identification of survivors for inclusion in this study was undertaken by the counsellor. The survivors were then referred to the research assistant for consenting purposes with the assurance that their participation and/or non-participation in the study would not affect the services they would receive at the facility. The survivors aged above 18 years were requested to give consent. Those under 18 years had consent obtained from the parent/guardian who had accompanied them to the facility. Survivors who agreed to participate were interviewed after they had received the services in a private room within the hospital.

Privacy: The interviews were conducted in private spaces identified within the various departments. The purpose of this was to ensure open discussions with the participants in spaces where utmost privacy was facilitated to enable the participants to candidly and freely contribute to the study topic without unnecessary disturbances.

3.10. Conclusion

There are strengths and limitations to the use of a mixed-methods study, especially regarding a study on sexual violence. Some of the limitations include the small sample size for qualitative data due to the social factors which influence the discretion with which cases of sexual violence are handled and often not reported due to stigma. There also exist challenges in interviewing survivors post the assault to examine their experience with care from when they reported the case to when they would complete or completed the treatment or the legal processes. While it would be prudent to do a prospective follow up of survivors to establish their uptake of referrals, this would not only be expensive but also time-consuming as it is not possible to determine when a particular case will be reported and at which service delivery point. A review of data maintained for survivors would ideally be considered more appropriate as it does not in any way evoke emotions. However, as would be illustrated in the subsequent chapter, inconsistencies in data capture procedures resulting in the poor quality of data remains a hindrance.

Chapter 4 QUANTITATIVE RESULTS GENERATED FROM SERVICE STATISTICS

4.1. Introduction

This section presents the findings of the data obtained for survivors who had accessed post rape care services from June 2013 to June 2014. These include data from multiple service delivery points, namely outpatient departments, comprehensive care clinics, laboratory, and trauma counselling departments. This includes data obtained from health facilities, where data was captured using the patient's name in an effort to track the survivor across the different points of care. Non-health related services were obtained from the court and police stations.

4.2. Study findings

4.2.1. Distribution of the number of records

In this study, a total of 1259 (with 75 records omitted as they did not have the requisite client identifiers to determine if they were for survivors of sexual violence) records were extracted, 983 (78%) from facility records and 276 (22%) from police and court records as outlined in Table 6 below. The facility data were distributed by service points as follows: 401 (41%) laboratory, 256 (26%) PRC register, 182 (19%) PRC forms and the rest from the trauma and P3 at 144 (15%). Police and court records were distributed in approximately equal proportions with the occurrence book register and charge sheet at 94 (34.1%) and 93 (33.7%) respectively, and with court records at 89 (32.2%).

Table 6: Sources of data by service points and data source

	Data source	Frequency (n)	%
Facility service records	Laboratory	401	41.8%
	PRC register	256	26.0%
	PRC-form	182	18.5%
	P3 form	82	8.3%
	Trauma counselling register	62	6.3%
	Total	**983**	
Police and court records	Occurrence Book (OB) register	94	34.1%
	Charge register	93	33.7%
	Court	89	32.2%
	Total	**276**	
Distribution by data source	Facility service points data	983	78.1%
	Police and court records	276	22%
	Total Records	**1259**	

Table 7 below shows that more survivor cases were reported in Naivasha facility compared to Gatundu facility in the period under review. This data shows, the difference between the two sites was statistically significant. This is congruent with media reports in Kenya, which have continually highlighted high cases of sexual violence in Naivasha due to the large population that resides there as compared to Gatundu.

Table 7: Sources of data by the service point

Source of Data	Gatundu County n (%)	Naivasha County n (%)	P-value
Police and Court	144(31.2)	126(15.9)	
Facility records	317(68.8)	666(84.1)	
TOTALS	**462**	**781**	0.0001

4.2.2. Socio-demographic characteristics of the survivors who received care

According to the National Guidelines on the management of survivors of sexual violence, health providers attending to them are required to capture all three names of the survivor as documented in the national identification documents (first name, middle name and surname), their age and their gender for those presenting at the health facility for ease of referrals. The records review sought to establish whether there was a significant difference in reporting of cases of sexual violence based on predisposing factors such as age, and sex, and the need presented by the survivor as per the type of sexual violence reported.

Age of survivors seen: Table 8 below shows that 885 (70.6%) of the survivors were aged below 18 years. The majority of survivors below 18 years classified as defilement were from Gatundu facility at 118 (56%). However, in 73 (5.8%) of the records retrieved, age was not recorded and was distributed by the facility with Naivasha at 42 (57.5%) and Gatundu at 31 (42.5%) facilities respectively. The mean age in the study was 15.7 years, with SD=11.1 and ranging between 1 – 80 years. The statistically significant risk ratio reveals that children were 21.194 times more likely to report upon being defiled (RR = 21.194, 95% CI= 5.388 – 8.363, p<0.0001).

Sex of survivors: Table 8 below shows that significantly more female(n=665;68%) compared to male survivors (n=318; 32%) were attended to in both facilities. Similarly, more females reported to the police 242 (89.6%) with a significant association between survivor's sex and reporting to either police or facility to receive a service. The statistically significant odds ratio

reveals that males are 1.786 times more likely to be perpetrators (OR = 1.786, 95% CI= 1.168 – 2.732, p<0.0001).

Survivors names documented: Table 8 below shows a discrepancy in the capture of the survivor's demographic information across the different data tools. While three names (first name, second and surname) of survivors should be recorded in all facility forms, only just under a third (30.1%) of the records had all three names recorded while 69.8 per cent had only two names recorded, the first and second. Of the survivors who had all their three names recorded, a higher proportion of 69.8 per cent was from Naivasha County, and this was statistically significant (p=0.003). While just over half (53.1%) of the P3 forms had all the three names required recorded, only half (50%) of the PRC forms had all three names of the survivors indicated, as required during the completion of the form by the examining medical officer, while 4 per cent from the PRC register had the three names indicated. In Kenya, most communities share the maiden and surname, hence the reason why the first name would help in ease of identification. Similarly, on the PRC Register, hardly any (3%) had all three survivor's names indicated. The results p=<0.001 illustrates the significance in documenting the full names of each survivor for purposes of referral and/or ease of differentiation of clients who might share at least two names. The use of three names helps avoid misfiling of client data. For example, from the review of the PRC forms and register, 4 per cent of the entries were found to bear similar names hence presenting challenges in determining if they were two different clients or a double entry of one client. Additionally, some forms would lack basic demographic information such as age and sex. This could make it difficult to ascertain if it is the same individual who has had their

information entered more than once, (multiple sexual violence presentation) or if it is different individuals with similar names seeking medical assistance after sexual violence.

Type of sexual violence: Table 8 below shows the types of sexual violence as reported by the survivor as recorded on the forms. Results showed however that in 757 (60%) of the records, the type of sexual violence was not recorded with a higher proportion of unrecorded sexual violence in Naivasha 517 (65%) compared to Gatundu at 240 (52%). The most common form of sexual violence reported was defilement 211 (42.5%) with a higher proportion of defilement cases reported in Gatundu 118 (56%). In all the health facility records reviewed, there was no standard way of recording different types of sexual violence. Facilities either recorded the part of the sexual reproductive organ where the penetration occurred, while some recorded the type, i.e. rape, defilement etc. The other gaps identified was in the documentation of the type of sexual violence where 76.7% of the records did not indicate the type of sexual violence. The most commonly used terms to document sexual violence whether rape or defilement included "vaginal: (15.2%), "penile-vaginal" (3.8%), "penile-anal" (2.3%) and/or anal (1%). There is a significant chi-square association at ($p<0.001$) between the proportion of the sexual violence cases reported and reporting facility offering services.

Table 8: Records reviewed by socio-demographics

Variable	Source of Data	Description	Gatundu PGH n (%)	Naivasha PGH n (%)	Total n (%)
Number of Names indicated (n=967)	Lab(n=399)	Two names	116(34.7)	218(65.2)	334(83.7)
		Three names	7(10.77)	58(89.2)	65(16.3)
	P3(n=81)	Two names	0(0)	38(46.9)	38(46.9)
		Three names	2(4.7)	41(95.3)	43(53.1)
	PRC Register(n=249)	Two names	107(44.9)	131(55)	238(95.6)
		Three names	1(10)	9(90)	10(4)
		One name	0(0)	1(100)	1(0.4)
	PRC Form(n=176)	Two names	21(22.6)	72(77.4)	93(52.8)
		Three names	2(2.4)	81(97.5)	83(47.2)
	Trauma(n=62)	Two names	56(94.9)	3(5.08)	59(95.2)
		Three names	3(100.0)	0 (0)	3(4.8)
Age (n=967)	Lab (n=398)	No age recorded	6(66.7)	3(33.3)	9(2.3)
		<18 years	68(26.6	188(73.4)	256(64.3)
		>18 years	49(36.8)	84(63.2)	133(33.4)
	P3 (n=81)	<18 years	1(1.5)	64(98)	65(80.2)
		>18 years	1(6.2)	15(93.8)	16(19.8)
	PRC Register (n=250)	No age recorded	0(0)	3(2.1)	4(1.2)
		<18 years	81(43.3)	106(56.7)	187(75.1)
		>18 years	27(45.8)	32(54.2)	59(23.7)
	PRC Form(n=176)	No age recorded	4(33.3)	8(66.7)	12(6.8)
		<18 years	15(11.7)	113(88.3)	128(72.7)
		>18 years	4(11.1)	32(88.9)	36(20.5)
	Trauma(n=62)	No age recorded	1(1.7)	0 (0)	1(1.6)
		<18 years	45(95.7)	2(4.3)	47(75.8)
		>18 years	13(92.9)	1(7.1)	14(22.6)
Sex (n=967)	Lab(n=399)	Male	27(38.6)	43(61.4)	70(17.5)
		Female	96(29.2)	233(70.8)	329(82.5)
	P3(n=81)	Male	1(8.3)	11(91.7)	12(14.8)
		Female	1(1.4)	68(98.6)	69(85.2)
	PRC Register(n=269)	Male	30(62.5)	18(37.5)	48(19.3)
		Female	78(38.8)	123(61.2)	201(80.7)
		Male	3(15)	17(85)	20(11.4)
	PRC Form(n=172)	Female	20(12.8)	136(87.2)	156(88.6)
		Male	15(93.8)	1(6.2)	16(25.8)
	Trauma(n=46)	Female	44(95.7)	2(4.3)	46(74.2)
Type of Sexual violence (n=225)	Lab (n=2)	Rape	1(50)	1(50)	2(100)
	PRC Register (n=1)	Rape	1(100)	0 (0)	1(100)
	PRC Form (n=162)	Defilement	16(13.4)	103(86.6)	119(73.5)
		Rape	6(14)	37(86)	43(26.5)
	Trauma (n=60)	Defilement	44(97.1)	1(2.2)	45(75)
		Rape	15(100)	0 (0)	15(25)

Table 9 below indicates that a total of seven (1%) of the retrieved cases reported incest. The cases were all female and under 18 years as their ages ranged between (6 – 14 years with a mean age of 10.5 years). The reporting rates of cases of sexual violence ranged from less than 24 hours, two, and four days respectively, with one survivor reporting after six months, as shown in Table 9 below.

Table 9: Documented cases of incest and duration of reporting for care

		Incest cases reported	
		Count	% within
Facility	Naivasha	5	71.4%
	Gatundu	2	28.6%
Total		7	100%
Age survivors(years)	6	1	14.3%
	7	1	14.3%
	11	2	28.6%
	12	1	14.3%
	13	1	14.3%
	14	1	14.3%
Total		7	100%
Duration of reporting after the incident	1 day	1	25.00%
	2 days	1	25.00%
	4 days	1	25.00%
	6.4 months	1	25.00%
Total		4	100.0%

Knowledge of assailant: Table 10 below presents data abstracted from the PRC forms on knowledge of the assailant. Results indicated that 87 per cent of the survivors in Naivasha hospital with only 19 per cent of those from Gatundu hospital reported knowing their assailant and reported the issue to police. There was no significant association between the type of Sexual violence reported and knowledge of survivor, as shown in Table 10 below. Univariate analysis

reveals that rape survivors are eight times more likely to report and access service (OR = 7.563, 95% CI= 5.552 – 10.302, p<0.0001)

Table 10: Type of sexual violence documented and survivor knowledge of the assailant

Variable	Description	Facilities		Totals	Chi-Square	P-value
		Gatundu(n=315)	Naivasha (n=652)			
		n(%)	n(%)			
Type of sexual violence	Defilement	98 (44)	120 (56)	218 (77)	0.909	<0.0001
	Rape	15 (48)	16 (52)	31 (11)		
	Attempted defilement	9 (75)	3 (25)	12 (4)		
	Attempted rape	5 (50)	5(50)	10 (1)		
	Blank	1(25)	3 (75)	4 (1)		
Assailant Known	No	4(14)	24(86)	28(16)	0.116	0.775
	Yes	19(13)	132(87)	151(87)		
Reported to Police	No	3(7.5)	37(92.5)	40(22)	1.263	0.417
	Yes	20(14)	118(86)	138(78)		

4.2.3. Survivor reporting patterns for sexual violence

In this study, a review was undertaken to establish the time within which the survivors reported to the health facility. The National Guidelines on the management of survivors of sexual violence stipulate time within which survivors are eligible for HIV Post Exposure Prophylaxis (PEP), and Emergency Contraceptives (eligible female clients not on any modern contraceptive method).

Time of reporting post-assault: In order to establish the reporting patterns, this study made a comparison between the date when the sexual violation occurred as captured in the hospital records, against the date of initial reporting at the outpatient department. Most (84%) of the reviewed records across both health facilities had captured the date of the alleged sexual

violence and date of presentation of the survivor to the facility on the PRC register. Of all the sources of data utilized, only data from the PRC register could be used to establish the difference in time from the date when the alleged sexual violence occurred and date of reporting the same. . The reason for this is that layout of the PRC register makes it easier for the provider to capture both entries, as compared to the other forms. In the PRC Register, a total of 128 cases (34.4% Gatundu; 65.6% Naivasha) were reported before 72 hours compared to 108 cases (54.6 Gatundu; 45.4%), which were reported after 72 hours. However, 13 cases did not have the two dates indicated hence unable to determine the time difference. In the context of sexual violence, only those survivors who present within 72 hours are offered HIV PEP as per the WHO guidelines, which stipulate that PEP should be given as soon as possible and within 72 hours.

The documented first point of reporting: Eighty-two copies of the P3 forms which were retrieved from the two hospitals were reviewed for their completion, two from Gatundu and the rest from Naivasha hospital. The P3 forms indicate the date when the sexual violence occurred and filling in of the form is done. A reference number was given for every presenting survivor, if the incident was recorded in the occurrence book register and whether the survivor was referred to hospital, and if P3 is being completed elsewhere. The majority (84%) of the survivors who first reported to the police were females. Survivors aged 18 years or less (79%) were more likely to report first to the police. The ages of survivors who reported first to the police before going to a health facility ranged from two years to 75 years, with the mean age of 17 years. A further review indicated that more than half (57%) of the P3 forms indicated that the survivors had reported to the police within 72 hours from the date of the alleged sexual violence.

4.2.4. Post rape care services offered and documented

The National Guidelines stipulate that survivors of sexual violence are eligible to receive post rape care services which include history taking, physical examination, evidence collection, laboratory tests and counselling. These services are offered from different service delivery points, as illustrated in Figure 10, below imply that survivors are required to move from one service delivery point to the other.

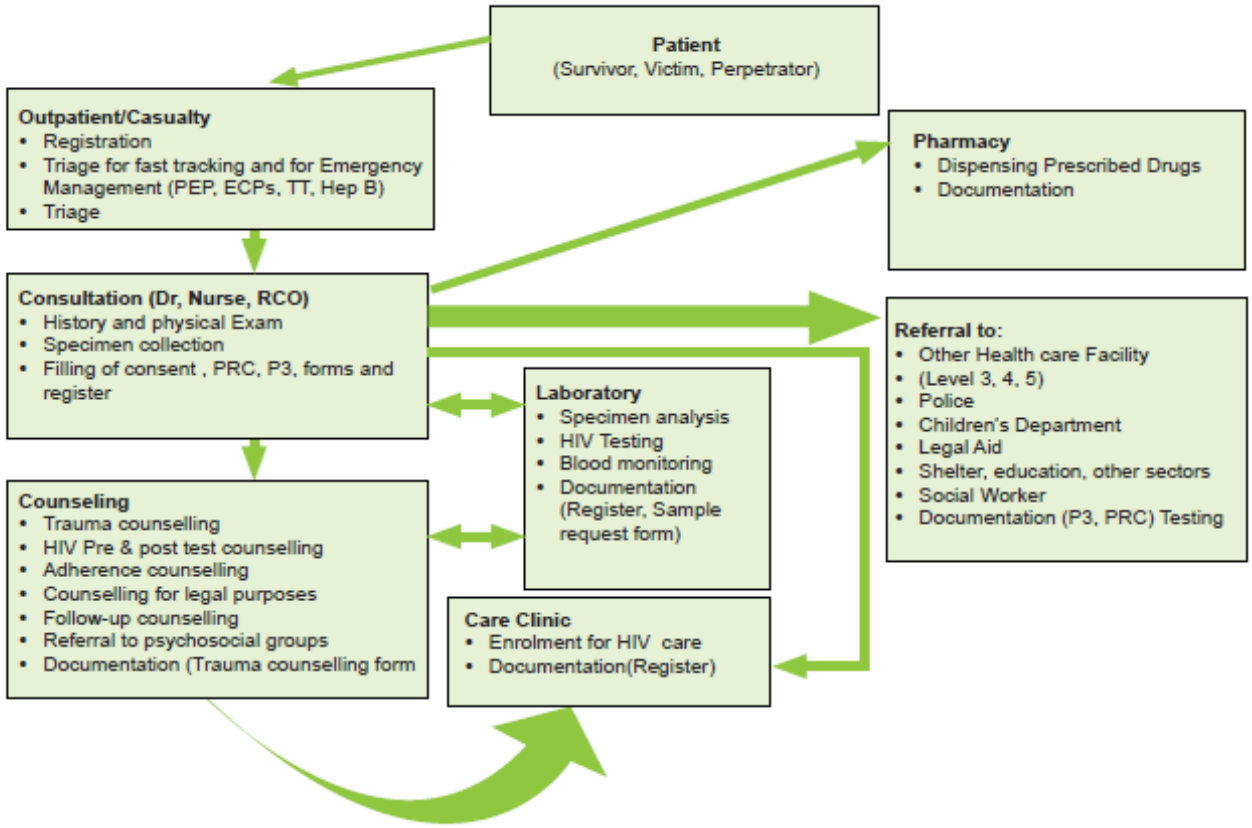


Figure 10: Patient flow pathway at the health facility

*Source: Obtained from the National health sector SOPs on sexual violence

It was established that in both facilities, the PRC services were located in different departments. A survivor was therefore required to follow different service delivery points during

service uptake. As earlier mentioned, services at these departments were offered by different service providers. Each of these service delivery points needs to capture the survivor demographics and service offered. A significantly higher proportion of the records obtained were from Naivasha (n= 666; 68%) compared to 317 (32%) from Gatundu hospital. This difference was statistically significant (p=<0.001). Most of the survivors accessed laboratory services. The review revealed that 401 (40.8%), of the records were obtained from the laboratory registers followed by PRC register (n=256; 26%), PRC Form (n=182; 19%), P3 (n=82 ;8%) and Trauma (register n= 62; 6%)

Documentation of forensic evidence obtained from survivors

The PRC forms reviewed indicated that contrary to the National Guidelines, the health providers only requested a selection of the specimens. The samples to be retrieved from survivors reporting in health facilities should include outer genital swab, anal swabs, skin swab, oral swab, high vaginal swab, urine, blood, pubic hair nail clippings, and any other foreign body. The samples are collected for either DNA or clinical treatment purposes based on the type of sexual violation reported.

Not all the laboratory samples that were necessary were collected. A significant majority of samples collected were: 84.8 per cent blood for HIV test (p=<0.001), 82.7 per cent Urine (p=<0.001) for pregnancy and STI testing, 69.2 per cent Blood for VDRL and 67.8 per cent HVS (p=0.05). External swabs were taken from the outside genitalia from child survivors given that a speculum exam is not recommended for children as per the National Guidelines. The proportion of survivors who had anal and/or skin swabs collected was pretty low within both health

facilities. Only 18.6%, 5.2% 0.6% and 23.8% submitted samples, namely the external swab, an anal swab, skin swab, blood and for HB tests respectively. There was a significant difference in the number of survivors who submitted samples from external swab and blood for HB testing. Comparison by site showed marked differences in the proportion of survivors who had the various samples taken, with those from Gatundu hospital less likely to receive some tests. For example, only 8 per cent of survivors seen in Gatundu had their blood taken for HIV testing, compared to 92 per cent of survivors seen at Naivasha. Similar trends were observed in the proportion of urine samples, HVS and blood samples for VDRL screening, as indicated in Table 11 below.

Table 11: Forensic samples collected and documented

Samples collected	Collected	Facilities		Totals	Chi-Square	P-value
		Gatundu	Naivasha			
		n (%)	n (%)			
External Swab	No	7(5)	138(95)	145(81.4)	45.532	<0.001
	Yes	16(52)	17(48)	33(18.6)		
HVS	No	11(20)	45(80)	56(32.2)	3.916	0.048
	Yes	11(9)	110(91)	1216(67.8)		
Urine	No	10(33.3)	20(66.7)	30(17.3)	12.643	<0.001
	Yes	13(9.1)	130(90.9)	143(82.7)		
Anal Swab	No	67(23.3)	221(76.7)	288(49.7)	0.024	0.877
	YES	79(27.1)	212(72.9)	291(50.3)		
Skin Swab	No	22(12.4)	155(87.6)	177(99.4)	0.148	0.701
	Yes	0	1(100)	1(0.6)		
Blood VDRL	No	115(47.9)	125(52.1)	240(41)	112.018	<0.001
	Yes	31(9.1)	308(90.9)	339(49)		
Blood HIV	No	10(8.7)	105(91.3)	115(76.2)	13.371	<0.001
	Yes	12(33.3)	24(66.7)	36(23.8)		

Survivor uptake of laboratory-related services

A total of 401 entries in the laboratory register were reviewed. Most (68%) of the referrals to the laboratory were likely to be from the Outpatient Department (p<0.001). Table 12 below illustrates that the most commonly offered tests were the high vaginal swab and/ or anal swab - 70% - followed by the HIV test - 67%. There was a statistical difference in samples documented in the two facilities. The likelihood of being offered these tests for survivors was much greater for those presenting at Naivasha compared to Gatundu.

Table 12: Laboratory services documented

Lab test	Description	Facilities		Totals	Chi-Square	P-Value
		Gatundu n(%)	Naivasha n(%)			
VDRL	No	104(57.1)	78(42.9)	182(45.6)	108.7	<0.001
	Yes	19(8.8)	198(91.2)	217(54.4)		
Hepatitis B test	No	90(58.4)	64(41.6)	154(38.8)	88.71`7	<0.001
	Yes	33(13.6)	210(86.4)	243(61.2)		
Urinalysis	No	92(59.7)	62(40.3)	154(38.6)	98.322	<0.001
	Yes	31(12.7)	214(87.3)	245(61.4)		
HIV Test	No	114(63)	67(37)	181(31.6)	1.96	<0.001`
	YES	32(8.2)	360(91.8)	392(68.4)		
Pregnancy Test	No	98(40.7)	143(59.3)	241(60.4)	27.617	<0.001
	Yes	25(15.8)	133(84.2)	158(39.6)		
HVS Anal Swap	No	45(38.5)	72(61.5)	117(29.3)	4.525	0.033
	Yes	78(27.7)	204(72.3)	282(70.7)		

It is worth noting is that not all survivors had their utilization of laboratory services documented in the laboratory register.

Uptake of prophylactic treatment and documentation patterns

Findings in this study show that Emergency Conception Pill (ECP) was recorded as being administered to 51 per cent of female clients. Survivors who had attended the Naivasha CH were

more likely to be recorded as having been administered ECP than those who attended the Gatundu CH (58.9%; p<0.001). HIV post-exposure prophylaxis (PEP) was recorded as being administered to 76 per cent of the survivors. (see Table 13 below).

Table 13: Prophylactic treatment received by survivors at a health facility

Prophylactic treatment	Description	Facilities		Totals	Chi-Square	P-value
		Gatundu	Naivasha			
		n(%)	n(%)	n(%)		
ECP	No	11 (12.9)	74 (87.1)	85 (49)	78.9	<0.001
	Yes	37 (41.1)	53 (58.9)	90 (51)		
PEP	No	15(26.3)	42 (73.3)	57 (24)	9.65	0.008
	Yes	88(49.2)	91 (50.8)	179 (76)		

Further analysis of the data presented in Table 13 above was undertaken to establish the proportion of survivors who presented within or after the initial 72-hour period important for PEP provision to be effective and within 120 hours for ECP provision to be effective. below demonstrates that of the survivors (data from PRC Register) 81.7% were provided with the initial doses of PEP within the 72-hour eligibility criteria for PEP. PEP completion data were not collected and is therefore undocumented on the PRC registers.

Table 14: Provision of PEP and ECP to survivors

Prophylactic treatment	Variable	Description	Facilities		Totals	Chi-Square	P-value
			Gatundu	Naivasha			
			n (%)	n (%)			
Age of Survivor							
Emergency Contraception	<18 years	No	8(11)	65(89)	73(39.2)	68.551	0.001
		Yes	21(42.9)	28(57.1)	49(26.3)		
	>18 years	No	3(27.3)	8(72.7)	11(18.6)	8.612	0.013
		Yes	16(41)	23(59)	39(66.1)		
Post Exposure Prophylaxis	<18 years	No	14(28)	36(72)	50(27.3)	7.375	0.025
		Yes	63(50.4)	62(49.6)	125(68.3)		
	>18 years	No	1(16.7)	5(83.3)	6(10.2)	3.344	0.188
		Yes	25(48.1)	27(51.9)	52(88.1)		
The time that is taken is by survivors before reporting to the facility							
Emergency Contraception	<120hrs	No	3(6.7)	42(93.3)	45(35.4)	29.662	<0.001
		Yes	17(31.5)	37(68.5)	54(42.5)		
	>120 hrs.	No	8(22)	28(77.8)	36(33.3)	3.611	0.057
		Yes	20(55.6)	16(44.4)	36(33.3)		
Post Exposure Prophylaxis	<72 hrs.	No	5(27.8)	13(72.2)	18(14.3)	1.788	0.409
		Yes	36(35)	67(65)	103(81.7)		
	>72 hrs.	No	8(26.7)	22(73.3)	30(28)	14.113	0.001

Further analysis by age indicated that some survivors less than the reproductive age of nine years still received ECP, (2%), despite not yet having begun puberty and therefore not a risk for pregnancy. Additionally, up to 15 per cent of the survivors who presented at the clinic beyond 120 hours from the time of the alleged violation received ECP. Beyond 120 hours, ECP is hardly efficient in conception prevention. The importance of this is confirmed by the small values of p=<0.001 for gender, age and time of survivors' presentation at the health facilities for the

administration of the ECP. A larger proportion of more than 50 per cent had presented themselves for PEP within 72 hours and this was significant at p< 0.002.

Survivor utilization of trauma counselling services

In Kenya, survivors are often referred for counselling upon receipt of the clinical and investigative services. In this study, data on the number of sexual violence survivors had received trauma counselling and which service delivery point they were referred from was obtained. A total of Sixty-two Trauma counselling forms were reviewed. Table 15 illustrates that more females than males received trauma counselling, as did those aged 19 years (75.8 %) or less. In addition, in both facilities, clients who had experienced a penile-vaginal type of sexual violence were more likely to be referred for counselling that those who had not.

Table 15: Clients documented to have received trauma counselling

Demographics		Gatundu CH n (%)	Naivasha CH n (%)	Total n (%)
Sex	Male	14 (23.7)	1 (33.3)	15 (24.2)
	Female	45 (76.3)	2 (66.7)	47 (75.8)
Age	<=19yrs	44 (74.6)	3 (100)	47 (75.8)
	20-29yrs	5 (8.5)	0 (0)	5 (8.1)
	30-39yrs	5 (8.5)	0 (0)	5 (8.1)
	>=40 yrs.	3 (5.1)	0 (0)	3 (4.8)
	Not indicated	2 (3.4)	0 (0)	2 (3.2)
Sexual violence type reported	Defilement	37 (62.7)	2 (66.7)	39 (62.9)
	Rape	18 (30.5)	1 (33.3)	19 (30.6)
	Not indicated	4 (6.8)	0 (0)	4 (6.5)

There was no statistical significance of uptake of counselling based on sex and age of survivor as illustrated in Table 16 below.

Table 16: Multivariate analysis of counselling uptake by sexual violence type

Variable	OR	95.0% CI	P-value
Sex	1.562	0.257-9.497	0.628
Anal	0.643	0.076-5.467	0.686
penile anal	0	0	1
Vaginal	0.836	0.217-3.23	0.795
vaginal Anal	8.87E+08	0	.
age recorded(1)	0.436	0.114-1.665	0.224

4.2.5. Documentation of services offered using medico-legal forms to track uptake and follow up of survivors

Follow up of cases of sexual violence accessing services is documented on the PRC register based on the complaint captured in the PRC form and services one is referred to. Of the 256 PRC register forms analyzed, 96 per cent of them indicated the survivor had a PRC form completed for them indicating all the referrals made. However, the follow up of cases to ensure survivors received P3 form was as low as 13 per cent, with those from Naivasha hospital who had P3 forms were at 33% compared to survivors from Gatundu at 9 per cent as illustrated in Figure 11 below. There was statistically significant ($p<0.001$) dependence between documentation of services offered using medico-legal forms to track uptake and follow up of survivors.

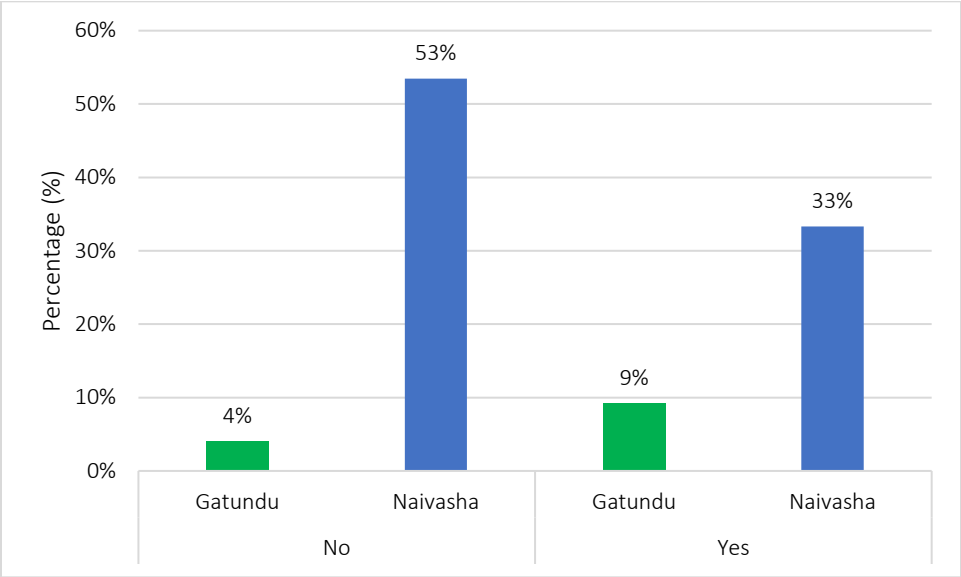


Figure 11: Proportion of survivors with medico-legal documentation

From the above analysis, it is not clear how providers tracked survivors accessing the different services without documenting the same in the PRC register, PRC and P3 forms.

4.2.6. Measures in place to enhance maintenance of the chain of Custody

As indicated in **Error! Reference source not found.**below, the majority (93%) of the original 182 PRC forms were given to the Police as part of the evidence of the chain of evidence process and duplicates were given to the survivor (86%). The odds of the survivors who presented at Naivasha hospital were more likely to be given copies of the PRC (OR = 2.15, 95% CI= 5.552 – 10.302, p<0.0001). Only 2 per cent of PRC forms documented had been signed by the police officer as required by the guidelines one of those who presented at Naivasha hospital had had their forms signed. This shows severe gaps in the chain of evidence and accountability mechanisms.

Table 17: The extent of maintenance of the chain of custody of documentation

PRC Form	Gatundu CH n (%)	Naivasha CH n (%)	Total n (%)	p-value
Signed by doctor	21 (91.3)	152 (95.6)	173 (95.1)	0.318
Signed by police	4 (17.4)	0 (0)	4 (2.2)	<0.001
Duplicate Copy to survivor	16 (69.9)	140 (88.1)	156 (85.7)	0.027
Original Copy to police	19 (82.6)	151 (95)	170 (93.4)	0.048

The study also sought to establish the coordination that exists between the police and health workers through the maintenance of the chain of custody of the document. Both police and health workers are required to sign the PRC form for it to be regarded as medical evidence. The study findings show a significance of <0.001 of the forms filled in Gatundu.

4.2.7. Pathways for trauma survivor entry point into the health care system

Table 18 below indicates that survivors who reported trauma were all from the Gatundu facility with a higher proportion of survivors being female at 41(73.2%). The majority 45 (76%) of the trauma counselling forms indicated that the survivors were referred from the police station to the hospital with counselling (Voluntary Counselling and Testing-VCT) being at 2 (2.3%), as the first point of entry after the alleged sexual violence among the survivors reporting trauma. It was also noted that 41(73.0%) of the survivors were aged below 19 years.

Table 18: Pathways for entry into care

Health Facility	Police Station n (%)	Health Facility n (%)	VCT n (%)	Other n (%)	Total
Gatundu CH	45 (80.4)	6 (10.7)	3(5.4)	2 (3.6)	56 (100)
Naivasha CH	0 (0)	0 (0)	0 (0)	0 (0)	0
Sex					
Male	14 (93.3)	0	1 (6.7)	0 (0)	15 (26.8)
Female	31 (75.6)	6 (14.6)	2 (4.9)	2 (4.9)	41 (73.2)
Age					
<=19 yrs.	30 (73)	6 (15)	3 (7)	2 (5)	41(73.2)
20-29 yrs.	5 (100)	0 (0)	0 (0)	0 (0)	5 (8.9)
30-39 yrs.	5 (100)	0 (0)	0 (0)	0 (0)	5(8.9)
>=40 yrs.	3 (100)	0 (0)	0 (0)	0 (0)	3(5.4)
Not indicated	2 (100)	0 (0)	0 (0)	0 (0)	2(3.6)

4.2.8. Uptake of services from the police station and referral pathways by demographics and type of sexual violence

Table 19 below shows a total of 94 Occurrence Book (OB) records, 93 charge sheet forms and 89 court forms were reviewed for cases reported to the police stations and thereafter entered into the court records. It further demonstrates that the greatest proportion of those who reported to the police station and had their sexual violence cases heard at the respective courts were females (241(87.3%) and the survivors aged below 18 years were the majority of the victims at 233 (84.4%).

The police officer to whom the case of the alleged sexual violence was reported was required to record the date of the alleged sexual violence and the date the report is made. Analysis of the 92 records in the OB registers (not presented in Table 19 below) showed that most forms (72%) did not have either or both dates, making it hard to determine whether there

was the time difference from date of the alleged sexual violence to the date the report was made.

Table 19: Cases captured in the police and court registries

Variables	Description	Reported to Police			Total	Chi-Square	P-value
		Charge Register	Court	OB Register			
		n(%)	n(%)	n(%)			
Sex	Male	15(42.9)	14(40)	6(17.1)	35(12.7)	5.113	0.78
	Female	78(32.4)	75(31.1)	88(36.5)	241(87.3)		
Type of assault	Other	0	2(66.7)	1(33.3)	3(1.1	10.861	0.028
	Rape	7(20.6)	8(23.5)	19(55.9)	34(12.5)		
	Defilement	84(35.9)	79(33.8)	71(30.3)	234(86.3)		
Age	No age recorded	3(15.8)	2(10.5)	14(73.7)	19(6.9)	17.429	0.002
	<18 years	82(35.2)	82(35.2)	69(29.6)	233(84.4)		
	>18 years	8(33.3)	5(20.8)	11(45.8)	24(8.7)		
Facility	Gatundu	54(36.7)	50(34)	43(29.3)	147(53.3)	3.3	0.192
	Naivasha	39(30.2)	39(30.2)	51(39.5)	129(46.7)		

Binary logistic regression analysis indicated that age(p=0.994), facility type(p=0.999) and sex(p=0.678) of the participants were not significant predictors of the cases being entered in police records.

Uptake of referral by survivors from different departments and institutions

According to the national multi-sectoral standard operating procedures for sexual violence, service providers are required to refer survivors for appropriate services. These include police, shelters, legal aid, counselling services and test facilities, support groups, children's department or any other institution based on the need presented by the survivors. These referrals can be to service delivery points within the same facility or other health facilities, and/or to non-health-related sexual violence survivors' services or institutions. Data collected from PRC forms and register indicate which services survivors were referred to. Also, similar

information is captured in the trauma counselling forms. However, there is a lack of a mechanism in place to notify the referring agent as to whether the survivor actually attended to the referral given. This section outlines findings on how referrals are effected.

Referrals within the health facility should be indicated on the PRC Form that is filled in at the Outpatient Department by the clinician and trauma counselling form at the Trauma Counselling Centre. Table 20 below shows the greatest number of referrals within the health facility, according to the PRC forms, majority of the referrals were for the laboratory tests (74%) and the least was to the Comprehensive Care Clinic (2%) for HIV PEP and further clinical management. Despite the low numbers of referral to some of the services, the records demonstrated that the medical examiner was aware of the availability of these services within the health facility for the sexual violence survivor. It is however unclear as to whether they used other mechanisms besides documenting on the PRC form to refer the survivors outside the health facility. The PRC form does not capture any further follow-up data whether the survivor took up these services. Hence, it's difficult to follow up on whether survivors attended the services referred to at all like counselling. For example, there was no way to tell if the sexual violence survivor was counselled once or completed all the five recommended counselling sessions after a referral from OPD to a trauma center. The recommended counselling schedule is that the first session should occur at the first point of reporting, the second session, one week after the sexual violence, the third visit at week two (post-sexual violence), the fourth visit at week four or six, and the last visit, three months' post-sexual violence. The review of the trauma counselling forms revealed that the majority (84%) of the survivors who initially received trauma counselling sessions, STI prevention and HIV testing referrals had a statistically significant

dependency with the facility offering the service ($p<0.05$). However, the uptake of the trauma counselling forms in both facilities indicated whether the clients took up the referrals for subsequent counselling sessions within the facility or not.

Table 20: Referrals within the health facility

Referrals	Gatundu CH n (%)	Naivasha CH n (%)	Total n (%)	p-value
PRC Form Referrals (n=182)				
Laboratory Tests	18 (78.3)	115 (73.2)	133 (73.9)	0.419
HIV Testing	17 (73.9)	113 (72.0)	130 (72.2)	0.533
Trauma Counseling	17 (73.9)	88 (56.1)	105 (58.3)	0.079
Outpatient Department	19 (82.6)	62 (39.5)	81 (45)	0.000
CCC	0 (0)	6 (3.8)	6 (3.3)	0.435
Trauma Counselling Centre Referrals (n=62)				
Trauma Counselling	52 (88.1)	0 (0)	52 (83.9)	0.003
STI prevention	47 (79.7)	0 (0)	47 (75.8)	0.012
HIV Testing	45 (76.3)	0 (0)	45 (72.6)	0.018
Pregnancy Test	17 (28.8)	0 (0)	17 (27.4)	0.375
Baseline Investigation (OPD)	7 (11.9)	0 (0)	7 (11.3)	0.694
Laboratory Tests	3 (5.1)	0 (0)	3 (4.8)	0.860
PEP	2 (3.4)	0 (0)	2 (3.2)	0.905

Documentation of cross-institutional referrals

Table 21 below shows whether the PRC Forms and Trauma Counselling forms indicated any referrals to facilities or services in sectors outside of the health sector for sexual violence survivors. Both PRC forms and PRC register indicate that the majority of the sexual violence survivors were referred to the police station to report their cases (82% and 87% respectively). The trauma counselling forms seem to capture most of the external referrals for post clinical and psychological management. However, in both sites, hardly any of the sexual violence survivors were referred to safe shelters (2%).

Table 21: Cross-sectoral referrals made for survivors and documented

Referral	Gatundu CH n (%)	Naivasha CH n (%)	Total n (%)
PRC Forms			
Police	17 (73.9)	133 (83.6)	150 (82.4)
Legal Service	16 (69.6)	60 (37.7)	76 (41.8)
Shelter	0 (0)	3 (1.9)	3 (1.6)
PRC Register			
Police	75 (69.4)	145 (99.3)	220 (86.6)
Legal Services	9 (8.3)	145 (99.3)	154 (60.6)

With every new sexual violence case presented at either the health facility or police station, a reference number should be issued that matches the one at each service. However, the records show that the reference numbers did not match at different service delivery points and institutions outside the facility. This has led to difficulty in tracing a survivor both within the health facility and across the different departments, and from the other referral institutions into the facility.

Summary

The findings presented in this study concur with those generated through previous studies on the provision of post rape care services in Kenya (Ajema et al., 2011a, Gatuguta, 2018, Wangamati et al., 2017a). In these studies, the need for a strengthened, collaborative approach to address sexual violence has been reported. However, findings of this study go a step further to show that while there are mechanisms to facilitate the cross-sectoral collaboration in response, huge gaps still exist. More so in the use of existing national sector-specific sexual

violence data reporting tools to not only document services offered but also make room for tracing and following up of survivors referred from one sector to the other.

In this study, the high reporting of cases of sexual violence amongst children was noted. Violence against children has been noted with concern in other surveys (UNICEF, 2012; UNICEF, 2014a). The recent violence against children survey (2019) conducted in Kenya showed that nearly half of females (46%) and more than half of males (56.1%) experienced childhood violence in Kenya. In addition, 63 per cent of females of childhood sexual violence experienced multiple incidents. The survey further revealed that only 41 per cent of female survivors of childhood sexual violence disclosed the incident to anyone. Also, only 12 per cent of females sought services, and 10.7 per cent successfully received services, and 3.2 per cent males sought services, and 3.2 per cent received the services (Ministry of Labour and Social Protection,2019). The gaps in reporting could be linked to fear of shame, lack of social support to facilitate reporting of cases of child sexual abuse, or lack of knowledge of where to seek help.

Delayed reporting of care or uptake on follow-on referrals could be associated with the normalization of violence due to prevailing social and gender norms. This has an impact on future victimization of survivors or increased risks to negative mental, and other health outcomes.

Weak data capture and reporting mechanisms across the institutions offering post rape care services is a key contributor to the poor quality of care available to survivors. In addition, lack of data also impedes healthy discourse amongst stakeholders at a multi-sectoral level on the requisite measures to enhance timely and comprehensive services to survivors presenting across

the different levels of care. While efforts exist towards enhancing data capture at service delivery points, there remains a gap on unified identifiers to enable tracing of survivors accessing services across different service delivery points, and institutions. Consequently, the review of the referral chain is only possible through the availability of data from the first point of reporting, which in Kenya, mostly is the health facility, through to the police and judiciary.

Chapter 5 SERVICES OFFERED TO SURVIVORS OF SEXUAL VIOLENCE, REPORTING AND REFERRAL MECHANISMS: QUALITATIVE PERSPECTIVES

5.1. Introduction

This study sought to generate empirical evidence to the practices observed in the provision of services to survivors of sexual violence and the predisposing factors to survivors reporting of cases. This section provides insights obtained from interviews with health providers, police, officers from the children's department, survivors of sexual violence or guardians of survivors aged below 18 years accessing services. In addition, the study aimed to highlight the present approaches utilized in the referral of cases of sexual violence

In this chapter, the results are presented by respondent type and the themes generated from the interview sessions. The themes were drawn from research questions centered on answering key questions on the practices observed in the provision of care and referral of survivors. For service providers, the key questions asked revolved around the description of survivors who report cases of sexual violence, type of services offered, where survivors opt to report cases of sexual violence, approaches utilized in referring survivors, and existing gaps in cross-sectoral referrals and coordination. For survivors and their caregivers, the focus was placed on their first point of reporting cases of sexual violence, knowledge of where to report, services received, referrals given and their uptake of the same.

Responses obtained from the different questions were grouped into themes. However, some of the responses cut across more than one theme resulting in the collation of certain

themes or using responses obtained from one theme to complement other themes. In this section, I present the findings into three categories:

- Service provider perspectives in the provision of PRC services with a focus on the predisposing and enabling factors to report by survivors.
- Survivors and caregiver experiences with service utilization to draw out what they consider as their need for reporting,
- Referral mechanisms to highlight how the layout and organization of service flow mechanisms impact on service utilization by survivors.

In this section, I will highlight how the various factors outlined in the Anderson Model are great determinants to the reporting of cases and uptake of services.

5.2. SERVICE PROVIDERS PERSPECTIVES ON SEXUAL VIOLENCE

This section outlines perspectives on cases attended to. They were obtained from health care providers, police officers, and officers from the children's department.

5.2.1. The characteristics of survivors reporting cases of sexual violence at the health facility and police stations

Respondents were required to provide insights into the socio-demographics of survivors who report cases of sexual violence with a focus on age, sex and socio-economic status. The questions asked included- i)-How many survivors of sexual violence received post rape care services over the last six months? and (ii) Who are most of the clients you see?

Health care workers interviewed reported to have attended to 90 and 100 cases of sexual violence in Gatundu and Naivasha hospitals, respectively in their course of the involvement in post rape care service delivery within in their facilities. Health care providers and policymakers interviewed provided their impressions of the socio-demographic characteristics of the sexual assault survivors to whom they provided services. According to the providers, most of the survivors who they had attended to in Gatundu and Naivasha health facilities were both boys and girls on average aged 15 years. Gatundu hospital registered the highest number of minors, below 10 years. The majority of these were boys. In contrast, Naivasha hospital had the majority of minors as girls of around 15 years of age.

The providers reported that some survivors were from middle-class families, while others came from families with a low socioeconomic status. In Naivasha, it was reported that some of the survivors had either been abandoned by their parents or were being raised by single parents, their stepmothers, or grandmothers. The low socio-economic status of the caregivers increases the vulnerability of children to continued exposure to sexual abuse. As one participant stated:

*"There are *in* some instances where the social-economic status is low. Because like the majority of them come from the side of Karagita. Karagita is an area which is economically low because most of the people who reside there work in the flower farms. You find that when children are left*

by their mothers, they are raped by people who are known to them, so that is why I'm saying [they] there are those areas where their economic status is low…" (Male Policymaker, Naivasha)

"[They] there are primary school-going children mostly defiled by their close relatives. Most of them are from the middle social class" (Female Counsellor, Gatundu Hospital)

One provider mentioned that some of the survivors, are not only school-going children but are also orphans. However, there were reported cases of abuse of toddlers < 3 years, youth and adult men and women.

"Most of the survivors let me say [they] are [e] primary school-going children and apparently it is like they are children from poor backgrounds, and maybe their mothers work in the flower farms, and so you find those children are disadvantaged and [orphaned] too." (Female counsellor, Naivasha hospital)

While the study did not set out to establish provider perspectives on perpetrators of sexual violence, this emerged in the context of the discussions on underlying reasons why there are instances of delayed reporting of cases of sexual violence. Health providers reported that perpetrators of sexual violence could either be close relatives, strangers, or persons well known in the community. In both facilities, most of the health providers reported that the perpetrators were persons well-known to the family, and some were even relatives. In some instances, perpetrators were the sole breadwinners hence challenging for some of these cases to be formally reported to the health facilities or police station due to fear of ostracization of the survivor by their immediate and extended family members.

*"One of the cases that ended recently involved a standard five, about thirteen years, she was defiled by the father. We have another one here in class five, but she was abused from standard three and was reported when she was in class five, and she was like retarded and could not perform properly. She was forced to repeat class five, and she was defiled by the father. I hear the father was released on bond, and the case has not been heard for us to be able to know how it is. We have another one [of] from class three, and she was defiled by father, and she is also waiting for the case to begin." (*Female in charge of Children's home, Naivasha*)*

Health providers reported that exposure to sexual violence within home settings presents a challenge to most child survivors. The reason for this mainly revolves around the inability to provide protection to survivors from further abuse due to lack of rescue centers for survivors. Fear of revictimization was also cited as a barrier to reporting of known perpetrators.

5.2.2. Limited knowledge of available services hinders survivor access to services

Healthcare providers reported that lack of information held by members of the public on when to report sexual violence incidents resulted in some of the survivors delaying reporting incidents and seeking treatment from the hospital. This implied that the evidence might have already been destroyed and, in addition, that the survivor might not be able to get HIV prophylactic drugs to prevent infection.

"Some of the challenges is that some of the survivors come when they are late and being late, I mean they come after seventy-two hours though not many" (Female Counsellor, Naivasha)

It was reported that the public did not have sufficient information on what to do and where and when to report incidents of sexual violence. According to the legal aid team, lack of information also resulted in the survivor inadvertently damaging evidence by washing or being encouraged to wash themselves and their clothing first before the examination, thus losing evidence that would have been key in the case determination.

"The biggest challenge is lack of information by members of the public, some of them are messing with the evidence they clean these girls [survivors], they clean their clothes and all that." (Male Lawyer, Naivasha)

5.2.3. Multiple factors influence the choice of the first point of reporting of cases of sexual violence

The National Guidelines on the management of sexual violence in Kenya stipulate the need for timely reporting of cases of sexual violence for purposes of provision of HIV and pregnancy prophylaxis and retrieval of forensic evidence. However, it remains the survivor's prerogative as to where to report a sexual violence-related complaint - whether to the police or health facility. Respondents were asked to share their perspectives on what informs a survivor's choice on where to report their complaints. The responses to this question were grouped into three themes, namely preferred the first point of reporting, the underlying reasons to non-reporting of cases, and motivators for reporting. These are expounded below.

Hospitals, police stations and schools are the first points of reporting

In Kenya, survivors of sexual violence have the option of choosing where to first report for medico-legal and/or psychosocial support. The most preferred first point for reporting a sexual violation by the survivors in both counties was found to be first to the hospital, then the

police station. In Naivasha, most of the survivors reported to the school before seeking health-related services in the company of their teachers. In Gatundu, survivors reported first to the hospital then to the police. In Naivasha, it was reported that in some instances, survivors reported to the nearest police station either in the company of chiefs or local administrators. This was attributed to reluctance by some providers to attend to cases of sexual violence before they are reported to the police station. This was due to the Sexual Violence Act of 2006, which states that sexual violence is a criminal offence.

"Most of these people [they] stay within the chief's area, the AP (police) lines; so, they report to them, and they are sent to the police station, and that's when they come here to report." (Female Police Officer, Naivasha)

"When we refer the survivor to hospital in most cases, we do escort them, so we go there we introduce ourselves, and then we tell them we do have a defilement case, and they come at odd hours like 3 a.m. They will be given a letter […] [then referred] to hospital for the check-up. However, from the hospital, they just send them verbally.

Interviewer: They don't come with any note

Respondent: they just tell them to go fetch a police officer or go to the police like that verbally.

Interviewer: Like before they are given treatment, or they get treated first then they are referred to you?

Respondent: No

Interviewer: How is it done?

Respondent: They […] [neither] treat them nor examine them; they just tell them this is a police case go and report to the police first." (Female police Officer Gatundu)

The above feedback by the police was, however, found to be contradictory to the response given by a counsellor from Naivasha who reported that "*after getting the treatment and the counselling, there is the filing of the PRC forms and then we send them to the police station where they report, and it is recorded in the OB then they receive the P3 and come back for the form to be filled in"*.

Healthcare providers in both health facilities reported that the health facilities are often preferred due to the confidence community members have in the health providers, the need to prevent contamination and/or degradation of forensic evidence, and to avoid unintended pregnancies and STI/HIV infections. The following reflects these reporting processes:

"Most fear of HIV infection. They come to us first; we give then prophylactic treatment. They are referred to the police later. But most come after they have reported" (Male Clinical Officer, Naivasha hospital).

"In terms of evidence, most of them want to preserve such evidence since they are accompanied by their parents" (Male Clinical Officer, Gatundu hospital).

However, according to the health providers interviewed, not all survivors reported to the hospital within the stipulated time of 72 hours for HIV prophylaxis medication, 120 hours for pregnancy prevention and immediately for forensic evidence retrieval. Some of the reasons given for this practice included limited knowledge on the time limitations for the various

interventions, while other reasons included the stigma associated with sexual violence at household, in schools and community levels. Survivors do not always take themselves to the police or health facilities. There are instances where they are escorted. In this study, both police officers and providers mentioned instances where survivors get accompanied to the hospital by police, the area local chief, village elders, children's officers and/or their parents/guardians.

This study also involved children officers drawn from the County children department mandated with reinforcing national child protection mechanisms. In Gatundu, it was also noted that most of the cases of sexual violence were reported to the children's officers by the survivors parents, the chiefs and also volunteering children officers in an effort to seek help and guidance on the next course of action after the violation had occurred. The police officers also received parents and guardians who reported to them for assistance in arresting the perpetrator, before reporting to the hospital. The main reason for those reporting to the hospital first (especially in Gatundu), was due to the fear of becoming infected with HIV and other Sexually Transmitted Infections (STIs) and the desire for testing or treatment. Other reasons provided by those caring for survivors included being able to have forensic evidence retrieved by health providers, in addition to obtaining a duly filled in P3 form so as to initiate the legal process.

"I brought him because I feared he might have been infected with a disease, any kind of disease, HIV/ AIDS, or any other" (Female guardian to a 10-year-old male survivor, Gatundu Hospital).

A variation to the department where survivors first reported to within the two hospitals was noted. For example, in Naivasha, survivors first present themselves to the Outpatient Department (OPD) for triaging, initial history taking to establish nature of complaint and

treatment to be provided, issuance of prophylaxis, examination and retrieval of forensic evidence before being referred to a counsellor stationed at the youth center within the health facility. In Gatundu, on the other hand, upon presentation at the outpatient department, the survivor is referred to the Comprehensive Care Clinic for further management, including trauma counselling. All these departments are handled by different providers who also attend to all the other patients with other health concerns, and not just survivors of sexual violence. This implies that survivors end up queuing for services upon referral from other departments if they are not escorted across departments. In addition, they are compelled to narrate their ordeal at each of these service delivery points, which is a traumatic experience. Finally, these departments are spread out in the facility (with distances of between 10 meters to 50 meters, from one to the next) which survivors have to cover on foot.

Cultural taboos and fear of victimization impede reporting of cases of sexual violence

Counsellors interviewed indicated that some of the survivor's family members sometimes decided to hide the sexual violence incident and not report it to the police for fear of the perpetrator being arrested. This was more pronounced in cases where the perpetrator was a family member (father, spouse, sibling), the breadwinner, or someone well known to the family. According to health providers in Gatundu, the stigma and shame associated with sexual violence contribute to the non-reporting of sexual violence. Fear of exposing the survivor to harm from the extended family was also reported as a barrier to help-seeking. Some of the survivors delayed reporting the incident either due to lack of knowledge on where to report, available services, or fear of disclosure of the abuse due to stigma. This delays survivor getting to the

hospital for treatment within the recommended 72 hours, expose them to infections as a result of sexual violation.

"We have tried to do some awareness insisting that they should report to the hospital so that they can get treatment and care and especially the issue of rape and the 72 hours. Majority of the people now are conscious about it, so I believe that is why they first of all report to the hospital so that they can get the treatment before going to other areas. Yes, there those who come because […]majority of them […} [have been first prompted by] the awareness that has been done in the community […] [They], come to the hospital and then they go and report to the police. From the hospital to the police, they are quite aware, but with other institutions, they ask for help" (Female Counsellor, Naivasha Hospital*).*

Non-reporting of sexual violence was also noted in incest cases which, according to cultural practices are locally arbitrated by clan elders and not police officers who do not ascribe to the clan ethos.

*"… sometimes a case comes here, and they just say[…] you just want to finish it at home because somebody who did it was an uncle or family members, so we don't want it to be a police case"- (*Female Police Officer-Gatundu*).*

Children's officers stated that many cases of sexual violence *were not reported in Gatundu, as compared to Naivasha. "…. the client refuses to report and go to the hospital for treatment. Family members choose to hide the assault and deal with it amongst themselves"* (Female Counsellor, Gatundu hospital).

The fear of reporting was also associated with the age of the survivor and cultural taboos on discussions around sex. According to one police officer in Gatundu, elderly survivors find it difficult to report their ordeal to police as most of the cases are handled by police officers that are young enough to be their children.

"I have seen a case of an old woman of about 85 years, who was raped by a boy of about 20 years of age. Such persons become shy to report to us due to the age barrier and taboos around them discussing topics around sex" (Female Police Officer, Gatundu police station).

However, one police officer reported that awareness creation sessions conducted at the community level place emphasis on the police station as the first point of reporting. Reasons for this was to enable survivors to receive the P3 form before heading to the hospital for the form to be filled by a trained health provider. Both police and health providers interviewed in Naivasha mentioned that survivors mostly reported to the police first hoping that the suspect would be arrested faster.

"You see. When the chiefs have their barazas, they enlighten people when you get such a case the first place you are supposed to report is the police. Nowadays, villagers here are aware of such a thing has occurred to you, you report to the police" (Male police officer, Gatundu).

Efforts have been made to address some of the fears that community members have in reporting cases of sexual violence. In Naivasha hospital, the social workers reported that there had been a lot of community sensitization and public awareness on what needed to be done in the event of sexual violence, making the public more cognizant of what procedures to take.

Sensitization was done through the chief's barazas and Information, Education & Communication (IEC) materials-mainly posters, within the facility. It was therefore within the public domain and knowledge to report first to the hospital for treatment within the shortest time possible (preferably in the first 72 hours).

"*Maybe because a lot of sensitization has been done, and also people are aware that if anything happens, they should first go to the hospital before they go to any other place for evidence collection*" (Female Social Worker, Naivasha).

Fear of contracting infections motivates survivors to report to health facilities

Health providers interviewed indicated that in most instances, survivors opt to report to the health facility out of fear of contracting infections such as HIV/STIs, the awareness creation that has been done on the importance of reporting, and in some instances due to the key role played by health facilities in the retrieval and preservation of forensic evidence. In some instances, survivors choose to report to the police station in order to obtain the P3 form, which is key for legal determination of cases of sexual violence.

"… And we know most of the time when they report to the police station, they are given the P3. And the P3 cannot be filled without the PRC form. So, the PRC forms are filled" (Female counsellor, Naivasha Hospital).

"…. they need to see the doctor because it is traumatizing they need someone they can talk to […], and then in case […] there is the risk of getting an infection they need to be treated and then if it's a minor they have injuries they start bleeding so they have to see a doctor" (Male Medical Officer, Gatundu Hospital).

There was also a mention of sensitization sessions being focused on enlightening the community on the importance of timely reporting to the hospital for treatment and prophylactic treatment. As a result, one mentioned that,

"Majority of the people now are conscious about it, so I believe that is why they first of all report to the hospital so that they can get the treatment before going to other areas" (Female Counsellor, Naivasha Hospital).

5.2.4. Diverse services available to survivors at the health facility

The providers were asked to mention the type of services offered to survivors accessing care at their facility. According to the health providers reached, the services offered included physical examination and treatment, preventive care, counselling and referrals for non-medical services. These services are those that are supposed to be provided in accordance with the sexual offence Act medical treatment regulations (2012) and are offered free of charge.

Availability of prophylaxis for HIV and pregnancy prevention

Providers from both hospitals reported that survivors who present within the 72 hours post assault were offered the first dose of HIV prophylactic treatment. Female survivors who reported to the facility within 120 hours after the violation and were assessed not to be using any other contraceptive method were offered emergency contraceptives to prevent pregnancy. Both male and female survivors were put on STI syndromic management. Thereafter, survivors were given a physical examination, after which followed forensic evidence retrieval and laboratory tests. Preventive services were, however, only offered to those who presented within the stipulated timelines as per the National Guidelines.

"They (survivors) are registered; we don't charge them anything. They go to the clinician who takes the history, examination and treatment. We deal with the medical part where we test and treat for STIs. We give emergency contraceptives in case of pregnancy. We give them PEP to prevent HIV. ….. After physical and pelvic examination, we do a lab test to test for pregnancy, vaginal swab, we do VDRL, urinalysis, hepatitis B, hemoglobin test because some of these prophylactic drugs have some side effects, …" (Female Clinical officer, Naivasha hospital).

"PEP is given immediately and ECP. Mostly they are the drugs that are usually given first in consideration of the time. Then from there, that is when they go for the examination, the laboratory then they go to the pharmacy to collect the other drugs, then they come for counselling" (Female counsellor, Naivasha hospital).

Survivors receive the immediate prophylaxis within day one to three of reporting to a health facility. However, in some instances, reporting is done to facilities over public holidays or on weekends, and past 5 p.m.--when the pharmacy and laboratory services are unavailable--poses a barrier to survivor's receipt of these essential services.

Survivors undergo physical examination and treatment of injuries at the hospital

Health providers interviewed stated that survivors undergo a history taking, and physical examination before they receive prophylaxis or have their injuries managed. According to the health providers interviewed, the physical examination is undertaken to assess the level and extent of the injury and determine post rape care package to be offered in accordance with the provisions stipulated in the National Guidelines. All survivors are exposed to this phase as it helps generate information that is filled into the PRC and P3 forms. The examination was carried out in

both facilities undertaken at the outpatient department before the survivor is referred to the laboratory for the requisite investigative tests, and further on to the counsellor for psychosocial support.

"...with the physical examinations, they are done in the outpatient where they report. But if, as I said, if there is anything that needs further examination that is when we admit" (Female counsellor, Naivasha hospital).

". they need to see the doctor because it is traumatizing they need someone they can talk to someone, and then in case maybe there is the risk of getting an infection they need to be treated and then if it's a minor they have injuries they start bleeding so they have to see a doctor" (Female medical officer, Naivasha hospital).

Both physical examination and history taking occur hand in hand with the completion of the PRC and P3 forms. In both facilities, no counselling services are offered at the OPD or during the physical examination due to the absence of trained trauma counsellors at the OPD. Another reason is the high caseload of patients presenting with other non-sexual violence-related health concerns at the OPD (also referred to as emergency department in some facilities). It was also reported that documentation of the physical examination process does not always occur in tandem with the documentation due to the workload and amount of time required to fill in a PRC and P3 form during the examination, approximately 45 minutes to one hour.

Rape trauma counselling services available to survivors

In both health facilities, the survivors were referred to a trained counsellor based in the facility, to offer psychosocial support to them. This happened after the physical examination, and

history taking had been done, and prophylaxis issued to the survivors. At the OPD, the clinicians indicated that they only provide information to the survivors on the services they will receive at the health facility and direct them to the service delivery areas where they would get these services, namely the laboratory, counsellors, and wards (in cases where there was the need for hospitalization of a survivor for further management). Counselling services were also offered in follow up sessions to ensure that the survivor completed all the treatment and was able to get therapy for any mental or emotional trauma experienced.

"*I do adherence counselling, pre and post-test counselling, HIV testing, the importance of PEP and pregnancy prevention, importance of taking Sexually Transmitted Infection (STI) drugs and adherence to the clinic appointments"* (Female counsellor, Gatundu Hospital).

"when they come they are seen by the clinician, registered in the registry which is free they go to the clinician, they are sent to the laboratory, and after they are reviewed, to the pharmacy for collection of drugs, that is antibiotics and any other treatment that they could require depending on the severity of the client. They come for trauma counselling then we discharge them" (Female counsellor, Naivasha hospital).

However, providers from both health facilities reported that sexual violence-related trauma counselling services are only available during weekdays between 8 a.m. to 5 p.m. Survivors who report outside this schedule are often given a referral to present at the facility during the scheduled time. The counsellors were reported to play a key role in providing emotional support to survivors (and their caregivers) as part of therapy.

Collection and documentation of forensic evidence obtained from survivors

Providers from both health facilities mentioned that they obtain samples from survivors for treatment purposes as part of corroborative forensic evidence that is required for judicial purposes. The evidence obtained from survivors includes urine, blood, clothes and undergarments worn during the sexual violation, among others. As one provider reported:

"After physical and pelvic examination, we do a lab test to test for pregnancy, vaginal swab. We also do a VDRL, urinalysis, hepatitis B, hemoglobin test. In case a further test needs to be done, we refer to government chemists for example for DNA testing by taking the specimen there under the custody of police" (Female clinical officer, Naivasha hospital).

However, a provider from the Naivasha hospital alluded to the challenges faced in the collection of evidence and preservation of the custody of the evidence chain between the police and health facility. Some of the challenges cited included service unavailability on certain days. In Gatundu hospital, the filing of the P3 forms was done once, every Thursday of the week as this is the only day set apart by the facility for this process and other various issues including sexual violence. It was reported that in both facilities only the Medical Officers are authorized by the hospital to fill in P3 forms and attend court proceedings as expert witnesses. Those interviewed believed this posed a challenge to the survivors who came to the hospital on other days since they had to go back home and come back again on Thursday. In Naivasha hospital, it was reported that besides the P3 form being filled in by a medical officer on Tuesday and Thursday. There were instances where PRC form does not get filled in, especially on days when the medical officer who has undergone training on management of survivors of sexual violence is not on duty

for official or personal reasons. In such instances, survivors are required to frequent the health facility until such a time when these forms get filled in.

"After getting the treatment and the counselling, there is the filling of the PRC forms, and then we sent them to the police station where they report, put in the OB then they receive the P3s then they come back for the filling in of the P3" (Female counsellor, Naivasha Hospital)

"A P3 form, but now they are not filled immediately since they are only filled on Tuesdays and Thursdays. When they (Ahrens et al., 2007) go there they are only examined, and a PRC form is filled" (Female police officer, Naivasha police station*).*

Magistrates interviewed, however, mentioned that the court allows for any health provider conversant with the case, not necessarily a medical officer to present in court as an expert witness. They however also noted existing gaps in investigation of cases, as well as collection and documentation of evidence from survivors and at the scene of the crime.

" …, but mostly we don't acquit for none appearance of a doctor who is an expert, mostly because when it comes to cases of these nature, it's a must a particular kind of evidence must be availed to establish a case beyond a reasonable doubt, we check on the available evidence and find out whether it establishes the offence against the accused beyond a reasonable doubt, and mostly, of course, will actually give the good reasons allow enough time, reasonable time for the police and the hospital to organize coming of a doctor and the law is very clear, [if] the doctor that filled the p3 or the post rape care form is not available, we can call any other doctor who is conversant

with that doctor's handwriting and signature to offer evidence on their behalf" (Male magistrate, Naivasha law courts).

5.2.5. Health sector collaborates with other sectors in the management of survivors

The study sought to identify the roles of the different sectors entailed in responding to sexual violence. Besides the health department, the study participants stated that survivors also receive care and support from the police, children's department and the judiciary.

The police were reported to play a dual role in investigating cases reported to them and issuing survivors with the P3 form to aid in the judicial processes. Police officers in both Naivasha and Gatundu mentioned that their role also entails escorting survivors to the nearest health facility for management, and retrieval of evidence.

"*Immediately such a case has been reported, the first thing I do is to book the report, the report is booked in the occurrence book, and then we head straight to the hospital"* (Female police officer, Naivasha police station).

Besides their investigative role, the police also issue survivors P3 copies in duplicate to be filled in by the examining health provider at the facility. The police officers are custodians of the original copy of the P3 form which is submitted to court alongside the PRC form and the complainants' case file. The police by law also conduct investigation leading to the arrest of the perpetrator. One police officer supported this by stating that:

"If the accused person is known we use the administration officers like the chief and the administration police to arrest the accused person who is brought here (police station)." (Female Police Officer, Naivasha police station)

The children's officers interviewed from the County children's department reported that their main role is to rescue survivors and provide shelter as they await the court's ruling. This also includes children who report to health facilities but are unable to return to their homes for fear of victimization from the perpetrators. They also offer counselling services to the survivors as part of therapy.

"Our work is that when a sexual violence child comes, the first thing is to offer guidance and counselling so that that they can express themselves" (The officer responsible for managing children home X).

"Our role is basically rescue and referral. It entails rescuing children who have been sexually abused, referring them to hospital and linking them to facilities that offer psycho-social support as well as ensuring they get the necessary legal aid and the culprits are brought to book." (Female children's officer, Naivasha county Children's department)

In terms of rescue of survivors (mostly children) from abusive environments, the children's officer from Gatundu reported receipt of such cases from the local chiefs, neighbors and/or teachers. In such instances, their role entails rescuing the children and placing them in alternative homes, mostly children's homes owned by individuals or NGOs since the County does not have rescue shelter. The children's officers interviewed also mentioned that the survivor's

duration of stay in some rescue homes is dependent on the availability of space or policies in place.

*"In most cases what we do, is we call the homes and see if they have space. If they have space, we send the child. When the child is taken there either by the police or by a relative, in most cases the police or the chief, the homes are already waiting for the children because they have information and are expecting the child" (**Female children's officer, Naivasha county Children's department**).*

The police officers, health providers, and judicial officers interviewed, reported on the key role played by the judiciary in adjudicating all matters relating to sexual violence, which is a criminal offence by law. Their role, as reported by the police officers interviewed also entails working closely with the police investigating officers to summon witnesses from the community and/or expert witnesses from the health facilities.

5.3. PERSPECTIVES FROM SURVIVORS ACCESSING PRC CARE AND THEIR CAREGIVERS

This section highlights first-hand experiences shared by survivors (aged above 18 years) and caregivers who accompanied child survivors aged below 18 years. The study sought to determine whether survivors (and their caregivers) knew about the available PRC services and where to access these services, in addition to their experience with care-seeking. Survivors were asked to share their views on the availability of PRC services, reasons why they uptake (or don't uptake) these services, and challenges encountered in their access to services. I elaborate on their perspectives as per the themes below.

5.3.1. Survivors know where PRC services are offered

One of the female survivors interviewed cited that community members are aware of available services and where to report cases of sexual violence. The main sources of information cited included local administration, such as the chief, media stations, and social networking groups. In both counties, some of the sexual violence-related cases were reported to the village elders who in turn reported to the chief who consequently did the referral to the police.

*"I know, one television, we are told in the meetings, through attending counselling meetings conducted by some women, they used to come to tell us if anything of the sort happens and the first thing is to go to the hospital you get treatment first then you start to follow your case" (*29-year old female survivor, Naivasha).

Survivors and their guardians interviewed reported having knowledge on where to report, the importance of reporting to the health facility and police station, available prophylactic treatment and schedule for dispensing the medication, as well as the importance of reporting to hospitals within 72 hours. Such knowledge was obtained either from friends, teachers, or visual information in the community and hospital on what to do in case of sexual violence. Survivors and their guardians reported that posters pasted up at the hospitals were a source of information on what to do in the event of an occurrence of a violation. This contributed to the increased levels of awareness at the community level on how to respond in cases of sexual violence and where to seek help.

"I have heard and seen, and like now I have just read here outside. There some information and I can see how they look. So I have known about it because even now you can go

to see the doctor, the doctor will test you and tell you which drugs to take" (Female guardian to a 10-year-old male survivor, Gatundu Hospital).

In some instances, the survivors reported to only having knowledge of the services offered at the health facility and not in the other sectors. In Naivasha, it was highlighted that limited knowledge still exists on where to report. This justifies the reasons why some survivors still get referred to the local chiefs, who based on their knowledge, will either refer the case to the health facility, or police or opt to arbitrate between the survivor and perpetrator's family.

5.3.2. Services offered at a cost are a deterrent to reporting

Survivors reported varying experiences in accessing services depending on their County of residence. In Naivasha, the survivors reported having had ease in accessing services at the hospital since they were not required to queue; hence being attended to on time. The same was also reported from Gatundu.

"At the doctors when they knew about our case [we} were not asked to queue" (Grandmother of a 10-year-old male survivor, Gatundu hospital).

In terms of cost of access to services, it was noted that the survivors from Gatundu reported having had difficulties in accessing the health services since they were required to pay money at the hospital for filling in the P3 form. Most often only filled on Thursdays. This concurs with other participant reports that this often required them to return to the hospital. The following reports by survivors reflect survivor experiences:

"Then after coming from the police we came back here in the hospital with the P3, and we were asked to pay 500 shillings, we told them we didn't have" (Grandmother of a 10-year-old male survivor, Gatundu hospital).

In Naivasha, the cost to the access of the P3 form was not mentioned by a health provider whenever a survivor was accompanied by an officer from the Children's department as indicated below.

*"….*at the *hospital, people normally charge Kshs. 500 to fill in the P3 form. So, we would rather take them (escort survivors to the facility) because maybe they don't have that money to pay"* (Female officer, Naivasha children's Department).

One guardian in Gatundu reported having been requested for some money at the police station before being issued with a P3 form.

"…. We left the police station because we were told to give 500 shillings, and we didn't have money" (Grandmother of a 10-year-old male survivor, Gatundu hospital).

In Gatundu, one guardian cited instances where they pay for services to avoid any delays in receiving care.

"You know, when we reported first at the customer desk (health facility OPD), they should not have told us not to pay because they didn't know about our case. But since I wanted my child to be attended to, I just went and paid. Later we met with the police and the chief at the gate; they asked us if we have been treated, we said yes. They asked, did you pay for any services? We said,

"yes we paid because you the headmen you didn't come to help us, we called you yesterday and you didn't come" **(Grandmother of a 10-year-old male survivor, Gatundu hospital).**

Survivors and their guardians mentioned the shuttling they had to do across offices in an effort to obtain services from the hospital and police. The survivors who first reported at the hospital were treated, and PRC form filled out on the same day, then later referred to the police to report and obtain P3 form for filling out at the hospital. The P3 form would only be filled in if the survivor happened to report to the hospital on the day designated for P3 filling by a medical officer. Likewise, those who reported initially to the police were referred back to the hospital for treatment and later back to the police station to obtain the P3 form which is also issued at a police station before taking it back to the hospital for completion by a health provider. One survivor reported having made more than one trip to the police station before she had to be issued with a P3 form.

"We went there twice, in the morning when that girl (my school mate she recorded the statement and went back to school) went to record a statement and the second time when I went to the police station in the afternoon to get the p3 form" (18-year-old female survivor, Naivasha hospital)

In addition to the costs associated with filling of P3 forms at the facility level, survivors also reported incurring costs in purchasing drugs due to stock out of commodities in a health facility. This is represented below,

"I was done for all the tests after that I was given drugs, the first dose which I took immediately the ones which were not available in the hospital I bought. I was told how I would follow up the appointments, but the following day I came back here at the hospital" (29-year-old female survivor, Naivasha hospital).

It was noted by the survivors that the formal legal aid system and at times the health care system favors perpetrators more than the survivor. This was linked to cases where the perpetrator has a lot of influence (financial and authority) over how the reported case will be handled or can compromise the filling in of the PRC and P3 form with the intent to circumvent justice.

5.3.3. Too many trips made to the hospital and police by survivors

Survivors from both Gatundu and Naivasha hospital mentioned the several trips they had to make to receive post rape care. This is well represented by the experience of a survivor from Naivasha,

"When I arrived at the police station that same night, the police I found signed and gave me a note. So, the following day I didn't go back to the police. First, I came here at the hospital, I came, and I was counselled by a doctor (name withheld), and she filled the form (the P3 form) where it had not been filled then I went back to the police station—so going back to the police station with the form that's when I was given the police officer who would follow my case. After that I recorded statement, after that I came back here(hospital) because I was not given all the drugs, coming I was referred to the pharmacy and was given drugs for two weeks. After two weeks I came back and found Doctor (name withheld) who did counselling, and was given drugs for

another two weeks, I came back after 28 days I came, it was last week but one, that's when I finished taking the drugs, so I came and was tested, and I was happy with the results." (29-year-old female survivor, Naivasha hospital)

The same survivor reported having made two trips to the police, the first one to obtain a P3 form, and the second one to follow up on the case before subsequently giving up as cited below,

"I reported at the police report desk (for an occurrence book number which is given before a P3 is issued in some police stations), and they took my mobile number and other details. The following day when I came in when I was directed to the police officer who was to follow up on my case. We exchanged numbers, but I was never called or heard anything about the arrest of the suspect." (29-year-old female survivor, Naivasha hospital)

5.3.4. Fear of infection and assurance of justice are motivators to reporting to the police and/or health facility

Survivors and guardians from both counties gave similar responses to the reasons as to why they opted to report. Fear of HIV/STI infection was a sole motivator for them to visit a health facility, while the assurance that police would arrest the perpetrator provided a basis for them to report to police stations. In addition, survivors also mentioned that their reporting was driven by a need to obtain documentation to help prove they were violated.

"I brought him because I didn't know; first of all, because he is a boy and he is young he doesn't know, or he is not able to come to the hospital on his own. I also thought maybe that man is sick and if we assume and stay at home, it can be a problem to my child, so I decided to bring him, he

is tested for HIV, in case he is already infected with HIV, the doctor will advise me on what we can do" ***(Grandmother of a 10-year-old male survivor, Gatundu hospital).***

In cases of child abuse, the legal framework on child protection and rescue, which mandates children officers to take up cases of defilement was also found to be a motivator for reporting. One guardian mentioned that in an incident which entailed defilement of six boys (including her own grandchild), the community opted to report to the children's department whose involvement helped them in such a way that they did not have to pay for the P3 form despite having been initially requested to do by the provider. The children's officer also provided to support the guardians during the judicial processes, as stated below.

"Respondent: …. Then after coming from the police we came back here in the hospital with the P3, and we were asked to pay 500 shillings, we told them we didn't have.

Interviewer: who referred you to the children's office?

Respondent: Nobody, we decided to go there to ask for help, we decided to go back to the children's office, and if we do not get any help, we go back home to look for that money, the 500 shillings. When we got there the children's officer told us to wait since he was attending to other people, he later called us, he wrote a note, and we asked to bring it to the hospital. So when we gave them the note from the children's officer, the doctor asked us to give him the P3 forms, since it took us long it was late, and we were told that all the P3's is filled in only on Thursdays, so we were told to come back on Thursday and the doctor who was to fill them was not in, so we went back home. So, we left the P3, and we were told to come back on Thursday, and we come early. So, on Thursday, we came back very

early, they filled in the p3 for us, and we took it to the police. After we were given the p3's we met with the nurse she took the p3 forms and took them to the doctor who treated the children that's when the doctor filled in the other form (meaning PRC form) it was late, so we went home, that was on Thursday, we went back home, came back on Friday we were given the forms and took them to the police station. We were told that the perpetrator would be going for his mention in court. Another day I passed by the children's office and asked them whether it's a must we be attending court on mention, he told us there is no need, we only come during the case hearing" (Grandmother of a 10-year-old male survivor, Gatundu hospital).

The perspectives obtained from survivors and caregivers resonate with those obtained from providers as to the underlying reasons why survivors do not fully uptake services or report in a timely manner.

5.4. EXISTENCE OF REFERRAL MECHANISMS AND PATHWAYS FOR SURVIVORS OF SEXUAL VIOLENCE

Identifying the referral pathways from this study is important to help address the barriers that hinder survivors from navigating across the different sectors and departments involved in the provision of services. In this section, I highlight the experiences of survivors and guardians in pursuit of care from the different sectors. This section outlines the referral processes in place, factors that hinder uptake of referral and processes employed in referring survivors to non-health related services. Providers were asked to share their insights on how referrals are made.

5.4.1. Well defined referral processes within hospitals

In both health facilities, there was uniformity in the referral processes during the first visit made by the survivor. Health providers from both Gatundu and Naivasha hospitals cited the existence of mechanism through which clients got to know of the departments involved in the provision of PRC services including the signage displayed at the entrance to both facilities. In both facilities, survivors who accessed PRC services during the day reported at the triage desk located within the outpatient department before being referred to the provider on duty. Upon determination of the type of complaint and time of occurrence of the violation, the provider would then issue the survivors with prophylactic treatment for HIV and pregnancy prevention, as appropriate. The survivor would then undergo a detailed physical and forensic examination. Material/physical evidence such as clothes or undergarments worn during the assault would also be collected and packaged for transfer to the laboratory before the survivors are referred to the laboratory for specimen collection and analysis. The forensic samples are thereafter be packaged awaiting collection by the police for transfer to the government chemist for further forensic analysis. All these processes were documented in the PRC form and PRC register.

"After physical and pelvic examination, we do a lab test to test for pregnancy, vaginal swab. We do a VDRL, urinalysis, hepatitis B, hemoglobin test because some of these prophylactic drugs are metal toxic" (Female Clinical Officer, Naivasha Hospital).

The survivors are then referred for counselling while waiting for the laboratory results which would be sent directly to the clinician who attended to them at the outpatient department. Survivors who report at night are provided with prophylaxis and are either admitted

to hospital for the night or requested to return to the hospital the following day for the laboratory investigations to be undertaken. The results from the laboratory and counsellor are filled in the PRC form, and a treatment plan is drawn, medication is prescribed and dispensed at the pharmacy, the P3 form is filled in (for those who had reported first to the police station) and/or survivor referred to the police to report the case(in the event that the survivor did not report first to the police so that that they are issued with a P3 form to be completed by the health care provider).

> "*From the hospital, I left with three forms to the police station where they were signed by the police and the doctor I gave the police their copy, and I remained with my copy"* (29-year-old female survivor, Naivasha hospital).

The referral process is as summarized in Figure 12 below:

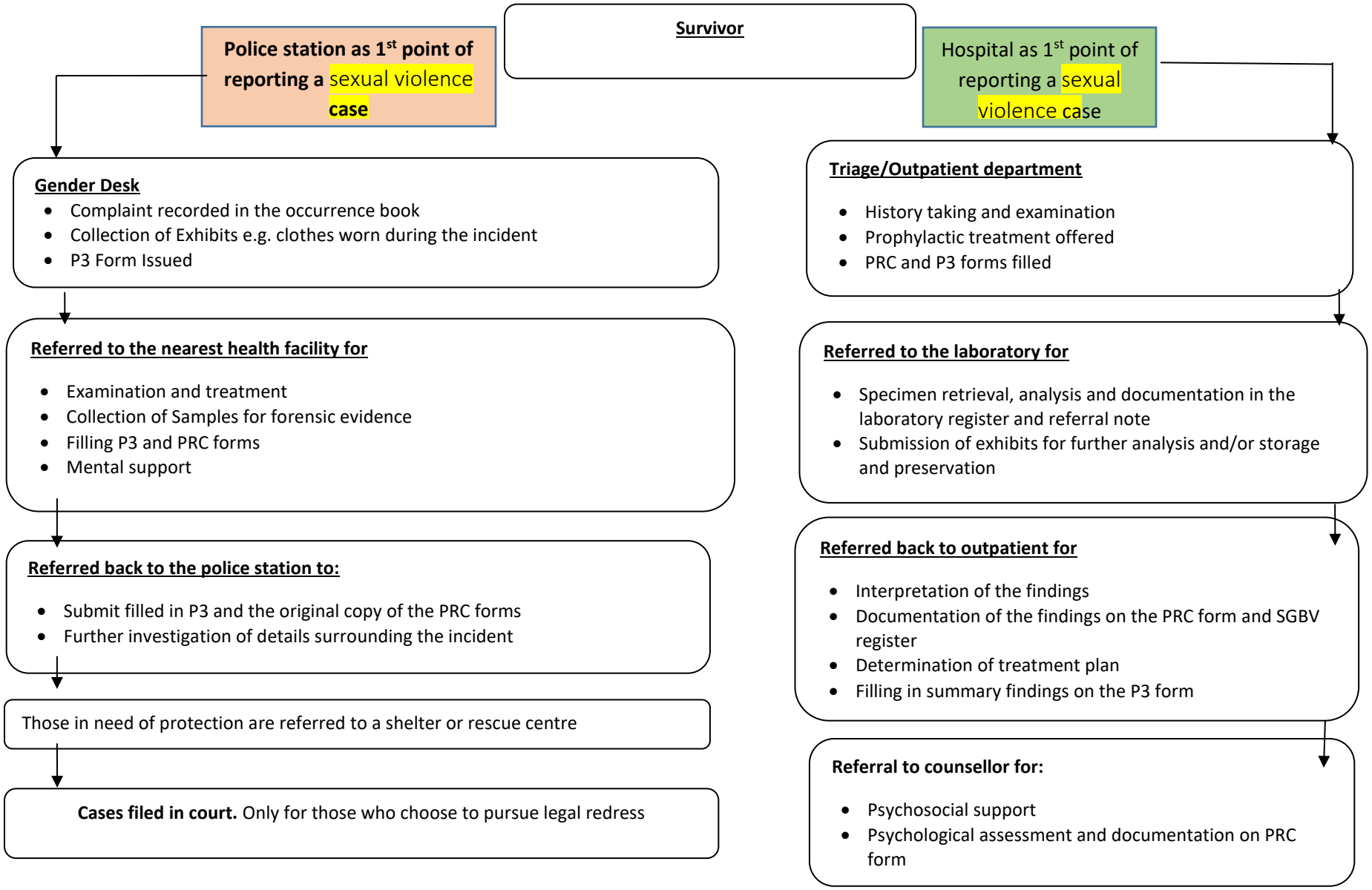


Figure 12: Survivor referral pathway as obtained from the responses from all the study respondents

5.4.2. Variances in the referral pathways and processes

Survivors in Naivasha exhibited knowledge of the location of the service delivery points where they were referred to within the hospital, hence needed no escort. In Gatundu hospital, a number of survivors were given directions to the referral point while others were escorted by the person referring them to keep them from queuing for services at the different service delivery points. Timeliness in the provision of services to survivors when in the company of children officers and or teachers were cited by survivors as per the quote below.

"I was taken to the police station (by classmates), but I was not interrogated they interrogated that girl who recorded a statement, and she went back to school. So I was later brought to the hospital by the principal I was treated, I was stitched and plastered, after that, I met with (provider name withheld) who brought me here (counselling room) she counselled me but not for long since I was still in shock," (17-year-old female survivor, Naivasha hospital).

In both facilities, the referrals issued were documented on the PRC forms. However, the PRC form does not have a provision to verify whether survivors accessed the services they had been referred to.

"We use the PRC form after finishing the whole examination, and it used to refer them to the police" (Male Clinical Officer, Gatundu).

Gatundu hospital has a referral directory that has been set up to ease the referral process, unlike in Naivasha hospital where referrals were done by writing on plain paper with no specific format.

"Depending on the case, sometimes we have to escort the patient sometimes we just make a call or do a letter, but it is not common most of them just go with the PRC form" ***(Social worker, Naivasha).***

However, while survivors in both health facilities are required to report first at the triage desk within the outpatient department, there were variations on where they were referred for counselling and further management.

5.4.3. Timely referral to hospital for treatment emphasized by police

Health providers from both counties cited instances where survivors opt to report first to the police station. This is either due to their proximity to the place where the incident occurs or based on the information they have on where to report a case or in the belief that the perpetrator will be arrested once a complaint is made at the police station. The two options are stipulated in the guidelines which allow for survivors to choose whether to report first to the police or health facility. In such instances referring to both counties, the police mentioned that the complaint is recorded in the occurrence book before the survivor is given a small note bearing the occurrence book number. They are thereafter referred to a cyber to make copies of the P3 form before heading to the hospital for examination, treatment and filling in of the PRC form. Police officers interviewed mentioned that the referrals to the hospital are made within the shortest time possible so as to ensure that the survivor was able to get treatment at a hospital a fast as is required.

"Immediately such a case has been reported, the first thing I do is to book the report, the report is booked in the occurrence book, and then we head straight to the hospital" (Female Police officer, Naivasha).

The health providers noted that in most cases, the survivors were referred to the police station to report the sexual violation, which is regarded as a crime against the State in Kenya. The police officers also reported that child survivors abused within their home settings are often referred to the children's department for shelter and protection. Referrals to the children's department in both Naivasha and Gatundu health facilities were handled by social workers.

5.4.4. Existence of uncoordinated and structured referral mechanisms

Whereas respondents across the different participant group interviewed in this study mentioned the existing referral linkages across sectors, the following gaps remain unaddressed:

Lack of referral uptake and treatment adherence monitoring

Healthcare providers from both Naivasha and Gatundu hospitals reported a lack of referral uptake and follow up mechanisms since there was no specific survivor tracking system in place. Adult survivors were reported to be responsible for ensuring adherence to the treatment schedule provided. However, most of the child survivors were found to be dependent on their parents and/or caregivers. The only existing monitoring mechanism for referral uptake and treatment adherence was when the patient returned for counselling. Part of the monitoring also entails undertaking laboratory tests to rule out any adverse effects associated with PEP and confirmatory HIV tests to determine a survivor's HIV status (for that tested negative at first visit) at week four and week 12 for post-assault.

"They come back for follow up. They are brought here by the people responsible in children homes and the police use the clinical card and lab results of the client" (Female counsellor, Gatundu).

Health providers and children officers reported that some of the survivors-both adults and child survivors did not reach the referral point. Lack of follow-up mechanisms imply challenges in tracking survivors who access case, identify gaps in services received and consequently contribute to attrition rates among survivors. The social worker from Gatundu also noted that the absence of a structured referral mechanisms hinders survivors' access to appropriate care and support as well as results in delays during help-seeking. Moreover, it increases the cost of access to services due to the different referral pathways that are neither well defined nor functional.

Distance and costs hinder the accessibility of referrals

According to the health care providers, the majority of the survivors access the facilities by foot or public transport. Public transport includes motorcycle taxis or "*matatus* "(Swahili word for a fourteen- seater Public Service Vehicle). Those who travelled on foot either did so due to their proximity to these facilities, or inability to afford public transport. Providers also stated that survivors at times visit the health facility unaccompanied or escorted by the police. Providers and police officers interviewed also reported a variance in referral approaches utilized. These included survivors being escorted by service providers, being issued with a referral note or contact initiated with the agency via telephone.

No framework for coordinating referral uptake across sectors, except for children

The health workers and police officers from both counties noted the existence of challenges in establishing uptake of referrals given across the different sectors. There were no referral frameworks to help confirm if clients took up and completed referral services. There was little feedback from the police and relevant children departments regarding the completion of the referrals made. While an informal referral network existed for those made between the hospital, the police and the children departments to help out the survivors, no official referral tools exist for referral between the various sectors in both Gatundu and Naivasha hospitals.

"It is more between the police and us but without any written or formal agreement but when they get a case that is being questioned, they refer the case to us for verification" (Male Clinical Officer, Gatundu Hospital).

However, in contrast to Naivasha hospital, Gatundu hospital reported the existence of a formal tool used for referrals specifically between the children's officer and the shelter. This stipulated the kind of services offered and the duration and terms of stay for the child survivor.

"The others have to pass through the children's office, and then the children officer brings them in person" (In-charge, Children home, Naivasha).

Limited shelters for both adult and child survivors

Social workers and children officers in both Naivasha and Gatundu reported lack of safe spaces for sheltering survivors as a major challenge in assisting survivors. There was a limited number of shelters (a majority are privately owned by individuals or Community-Based

Organizations- CBOs) hence posing restrictions on the number of survivors to be accommodated at any one given time. This presented a challenge on how to handle survivors who would not get shelter and yet still needed protection from their perpetrators, given that most of them were relatives or persons well known to the survivor's family. Some of the reasons given for the limited space included the lengthy court procedures since the children had to stay in the safe spaces until the case determination was complete for them to be taken back home. This kept the children longer in the shelters, limiting admission of any upcoming new cases. It was also risky to release them back to the family, as this would sometimes lead to repeated incidents of sexual violence. Overall, participants reported inadequacy of information on where survivors could be referred for long term support afterwards, and this was acknowledged by providers.

"Shelters for children homes are limited in the district (Female Clinical officer, Naivasha Hospital).

"In my case, it's a challenge getting shelter for a child who is [in]need of shelter. This is because we have limited homes, which is a major challenge" (Female Social Worker, Gatundu).

It was also noted that there were no shelters for survivors aged above 18 years, yet some of them still need protection.

"*We have problem with the shelter coz at the moment Naivasha has a shelter only for under 18 but when we get like very sensitive cases of over 18 years, and sometimes you don't know where to take them because there are no shelters that deal with over 18 years at the moment"* (Female Social worker, Naivasha Hospital).

Variations in survivor referral pathways and absence of structural referral mechanisms

Health providers mentioned the use of the PRC form to document referrals given to the survivors, specifically from the hospital to the police station. Other documents used for referral included the issue of a referral letter and a hospital card (which had the survivor's demographic information and details of the violation, and relevant information on treatment and other services obtained at the hospital). With regards to the referral of child survivors to the children's home, a plain paper (accompanied by a hospital letter) was used to write the survivor details while others only used telephone referral. In some instances, providers mentioned that the referral procedures are based on informal communication and linkages initiated by the health worker's and/or police. In a majority of cases, the survivors who first reported to the police stated that they were referred there by the local administration; mainly the chief or village elders. Sometimes the public also reported incidents of sexual violence to the chief, who in turn reported or helped refer survivors to the police before being sent to the hospital for treatment.

"Yah we normally ask, myself I would ask coz defilement or rape is a serious offence so we would ask them, have you already reported to the police and then also they normally come with a note from the police if they have already reported there they already come with a note that has the OB number, the date, and then the name of the person and then now they have reported a case of maybe defilement [stating], please assist pending police investigations. For those who do not have that note, immediately you attend to them then you have to advise them because you cannot follow them up to the police station, yah you advise them they need to report" (Male Medical Officer, Gatundu).

All the study participants mentioned variations in the issuance of referrals from the police station to the hospital. The common approaches utilized include the issuance of survivors with an OB number written on a piece of paper or a P3 form. The standard referral mechanism entails the issuance of a P3 form bearing the survivor demographics, and complaint presented, evidence retained at the police, OB number and name of investigating officer. In Both counties, police officers mentioned that all the cases of sexual violence are reported at the front desk before being referred to the gender desk and subsequently to the hospital for survivors who have the police as their first point of reporting.

"*Immediately such a case has been reported, the first thing I book the report, the report is booked in the occurrence book, and then we head straight to the hospital"* (Female Police officer, Naivasha).

However, one police officer reported the lack of a standardized approach to referrals and follow-up of cases that can be utilized to establish uptake of referral,

"… we have the P3 forms and at times have the contacts of survivors. We sometimes visit and check whether they stay, and because they know they have reported a case to the police, they disappear. You cannot find them where they were residing. They give you their mobile phones and when you try calling them it is switched off, so that case ends that way."

(Female Police Officer –Gatundu police)

Respondents from both police and health facilities cited the absence of structured referral mechanisms as a hindrance to survivors' access to appropriate care and support, resulting in lengthy procedures that cause delays to survivors.

"You find that sometimes when we refer them to the police, they don't reach the police station and that is why you may find that the numbers may not tally. We may send quite a number, but not all will get to the police station others will be compromised somewhere along the way, and that's why we feel that if the survivor can be accompanied by an officer, it would be good because we are sure the referral will get to its destination" (female Counsellor, Naivasha).

5.4.5. Lengthy court processes a deterrent to service utilization

Witnesses unwilling to testify

Social workers from both Gatundu and Naivasha cited that the lengthy court proceedings are a barrier to access to services. The lengthy procedures serve as a deterrent for some of the family members and members of the public to write statements and testify in the court were also cited as contributing to the long court process.

"When they go to those homes sometimes, and when the court ruling takes a long time, the homes don't want to keep the children there for long" (Female Clinical Officer, Naivasha Hospital).

Social workers also reported difficulties experienced by the police in getting witnesses to come to court to help testify on what transpired concerning the case. At times the lack of witnesses available was intentional, with the survivor's family members preferring to solve the case outside the court. The lack of witnesses contributed to the long court proceedings leading to the delayed court ruling and positive justice outcomes for the survivors.

"Court proceedings take long and when they are no people to testify the case doesn't follow through" (Female Clinical Officer, Naivasha).

"There is one we had who had been defiled by the uncle and getting people to testify in the courts was hectic" (Female Social Worker, Gatundu).

Lack of staff continuity and knowledge hampers expert witnessing

A further contributory factor to the long court process was the high staff turnover at the hospital. When the doctor who treated the survivor was transferred, this posed a challenge in getting another doctor to testify in court. Additionally, the police and magistrates cited that health providers on duty at times lack sufficient information and a good understanding of the violation case and consequently, may fail to give credible evidence regarding the case. This was especially seen in instances where their testimony would be, for the most part, based on the PRC form that might have been completed by a different healthcare provider.

"There is also the transfer of doctors, so we have so many, documents being submitted by doctors who never examined the survivor you find that they are not able to answer the questions, they are not able to bring the relevant evidence some of them do not make a forceful opinion" (Female Police Officer, Gatundu).

Summary

This chapter highlights provider experiences in the provision of services and experiences faced by survivors (and their guardians for those below 18 years of age) during service access. This data mirrors that which was obtained from the quantitative findings where a majority of cases of sexual violence involve children. The reporting of the cases of sexual violence is hugely influenced by both predisposing factors such as survivors age, community perspectives on how to handle such cases based on social norms. Various enabling factors greatly determine the

reporting of cases or uptake of services. For example, child and female survivors do not often have decision making power on steps to take upon being violated. Decision making is vested not only with the adults but more often than not with the male heads of the family due to the household gender dynamics. The data presented revealed the services received by survivors and whether these were offered as stipulated in the National Guidelines on the management of sexual violence. Further analysis of the survivor pathways to service access and referral mechanisms has been espoused. The referral pathways centered on inter-departmental referrals within the facility and external referrals to the police or safe shelters for legal aid and/or psychosocial support.

The lack of structured referral protocols for survivors both within and outside the health facility has been revealed in this study. Most providers make verbal referrals and fail to follow up to establish whether survivors took up the referrals given. In some instances, poor documentation of referrals made was also cited due to fear of some providers being required to present in court as expert witnesses. In some cases, survivors missed out on services due to the service levied before they are offered not only services but also given the requisite documents for legal redress. Survivors are still required to pay for the P3 form at both the police station and a health facility which is a barrier to most, especially those from poor backgrounds.

Chapter 6 DISCUSSION AND LIMITATIONS

6.1. Introduction

The theoretical framework applied in this study was based on the Anderson (1973) health utilization model. This section briefly discusses how the application of this model helped the researcher develop a better understanding of the factors that influence existing practices in the provision of services. Further, it looks at the factors determining referrals of survivors, reporting their behavior patterns based on their existing predisposing factors and needs. According to the Anderson model, three key factors play a significant role in influencing health-seeking behavior. These include (i) *predisposing* factors which entail an individual's socio-cultural characteristics and social structural factors; (ii) *enabling* factors – refer to the resources available to the individual to facilitate access to services; and (iii*) need* factors which revolve around an individual's own perception of their health status and the need to seek help (Andersen and Newman, 1973). A survivor's access to services is influenced by various socio-demographic characteristics such as age, sex, and attitudes towards a service. This was confirmed by results from the current study in which female and child survivors were most likely to report to either the police or health facility for services. Enabling factors such as service availability in terms of access, the model of service delivery, and costs were also outlined by respondents in this study as determinants of where to first report a case of sexual violence and also whether to take up available services or not. Finally, the survivors need to protect themselves from acquiring HIV/STI or getting pregnant (for female) as a result of sexual violence, were in this study reported as key motivators to service utilization.

Figure 13 below links the thesis findings to the Anderson health model and illustrates how these factors are fitted at different levels of the model framework. Worth noting is that some of the behaviors exhibited by survivors were cross-cutting. This implies the predisposing factors perceived to be associated with reporting a case of sexual violence were also responsible for influences by the family and cultural practices. This definitely determines where certain cases of sexual violence are to be reported and by who. In this study, the majority of the cases were reported by persons aged below 18 years, and not all of who received prophylactic treatment due to delayed reporting. This finding resonates with those of a study undertaken in Canada which linked reporting of cases of child abuse to the age, sex of the child and their relationship to the perpetrator. Knowledge of perpetrator is linked to delayed reporting of cases (Wallis and Woodworth, 2020). A study conducted in Australia revealed that reporting of cases among adult women is hindered due to family denial of the existence of violence and subsequently fear of bringing shame upon the family. These findings resonate with those generated through this study, where providers cited fear of shame and stigma as underlying reasons to non-reporting of cases to health facilities within the recommended 72 hours. Findings in this study confirmed the role of the community beliefs around sexual violence and disclosure of the same in influencing an individual's health-seeking behavior. For example, more cases of defilement were reported because the family feared that the survivor would contract STI/HIV. The stigma at the community associated with sexual violence was also cited as a great deterrent to reporting of cases of sexual violence. In this study, cases of sexual violence were reported more among females than males. The results support existing data generated on barriers to reporting of male victimization. A study conducted in Kenya refugee settings highlighted the fear of disclosure as

more pronounced among male survivors who fear being ostracized (Chynoweth et al., 2020). These findings are supported by a study by Overstreet and Quinn (2013), which demonstrated societal beliefs contribute to the stigmatization of persons who experience violence (Overstreet and Quinn, 2013). This refers to especially, those committed by an assailant well known to the survivor or their family despite the available services in health facilities, police stations and judiciary. This finding is supported by those generated from a study by Gatuguta (2018) which showed that in instances where the perpetrator was known, survivors were 38 per cent more likely to not receive HIV PEP compared to survivors where the perpetrator was unknown (11%) (Gatuguta, el.at.,2018).

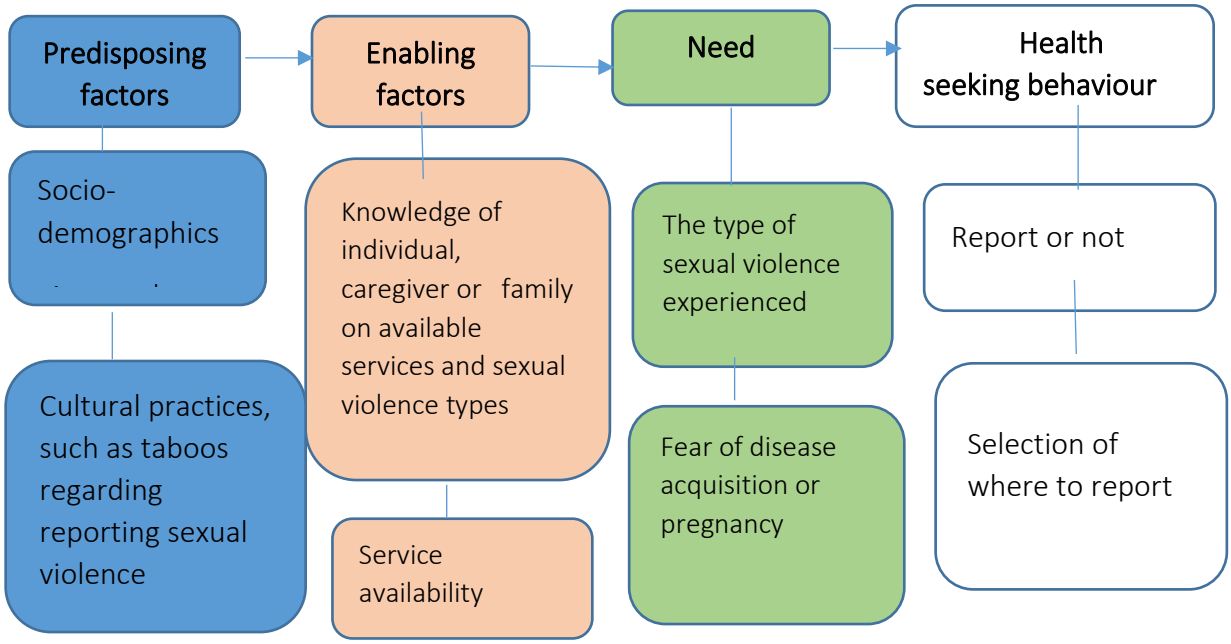


Figure 13: Predisposing, enabling and needs factors associated with health-seeking behaviour in this study

**Source: Adapted from Analysis of health service utilization of migrants in Beijing using Anderson health service utilization model (Shao, et, al. 2018).

The model above shows the intersectionality of the three factors that influence the survivor's choice of reporting to formal structures of support, and how their perception of consequences of sexual violence influences their preferred reporting to health facilities for disease prevention and to the police for justice. Understanding behavior around the utilization of available sexual violence and uptake of referrals enables us to identify the contextual realities that contribute to delayed reporting of cases of sexual violence. Similarly, it helps in pointing at reasons for poor linkage across different stakeholders despite the existence of anecdotal evidence indicating the need for a multi-sectoral response, as sexual violence is not just a health issue.

This study, therefore, sought to answer the following questions: (a) what are the current gaps and opportunities in the provision of comprehensive services to survivors of sexual violence in Kenya?, and (b) how can the current fragmented sectoral responses to sexual violence be addressed using a multi-sectoral referral and coordination framework? The discussions are centered around the application of a mixed-methods approach to achieve an in-depth understanding of the current status of cross-sectoral responses to sexual violence. The use of quantitative approaches provided the researcher with a platform to understand the magnitude of cases reported for services against their socio-demographic information and the disconnect in service delivery as documented in the service registers. On the other hand, the use of qualitative methods enabled the researcher to understand contextual issues to service utilization that cannot be obtained from service data. The quantitative findings were supported by qualitative findings from the study, which revealed discrepancies in service utilization, especially between the police and hospitals. The findings presented in chapters five, and six outlines the current gaps and

opportunities in the provision of comprehensive services to survivors, and measures required to address the fragmented cross-sectoral responses to sexual violence through the adoption of a multisectoral response framework.

The discussion is organized under the broad forms of data collection approaches used. Section 6.2 discusses the findings based on the analysis generated through the quantitative approaches, section 6.3, the perceptions from respondents to reporting cases of sexual violence, and section 6.4 provides my own reflections of the findings.

6.2. Discussion and interpretation of the quantitative findings

The study sought to establish uptake of services through a review of records maintained for survivors accessing services from the hospital, police and courts. This section centres on the study findings against existing literature and provisions of the Anderson model with a focus on the predisposing factors to reporting cases of sexual violence with emphasis on age and type of sexual violence experienced.

Factors influencing reporting patterns of sexual violence

In this current study, more females than males reported cases of violence to health facilities and police stations. In addition, over 77 per cent of the cases were reported by persons aged below 18 years. However, the results were based on service statistics and were not a population-based survey. Therefore, this is likely to be an under-estimate of the sexual violence prevalence. This is commonly the case everywhere else (WHO, 2013). There is documented evidence on the increased vulnerability girls face in the context of sexual violence compared to boys. The results support data generated from a multi-country study that showed high levels of

sexual violence against children. The study showed that approximately one in ten youth from Nigerian, Uganda and Zambia had experienced sexual violence (Nguyen et al., 2019). The occurrence of rape and defilement of females and children are linked to existing gender inequalities in the Kenyan society as in other sub-Saharan countries (Odwe, 2018; Ofwona, 2015). This resonates with findings from the KDHS (2014) which show that 38 per cent of violence occurs among women; and another study conducted among high school students which revealed a prevalence of 40 per cent among 15-19-year-old girls (Kabiru and Orpinas, 2009). However, in a patriarchal society where resources and decision making are controlled by men, the reporting of cases of sexual violence are compromised especially in instances where the violation is committed by the man who is the head of the family. These findings are similar to those generated from other studies in LMICs that show that most cases of sexual violence perpetrated by heads of households or male providers are rarely reported for fear of the family not having someone to provide for them upon incarceration of the perpetrator (Wachter et al., 2018; Weiss, 2010; Weitzman et al., 2017). One case study in Nigeria revealed how delayed reporting of a case perpetrated on a 17-year-old resulted in a pregnancy and termination of the same due to cultural taboos around children born out of incest (Oseni et al., 2016). In this study, it was also established that over 87 per cent of the survivors knew their assailant. From this study, it was established by providers that reporting of cases of sexual violence is also hampered especially where the perpetrator is either related to the survivor or is a respectable member of the society. Furthermore, in this study, girls were also found to be more vulnerable to incest. The cultural taboos around incest could also be associated with the low numbers (n=7) of incest cases that were documented during the period under study (June 2013-June 2014). In addition,

in this study, only 24 per cent out of 84 per cent of survivors who knew the perpetrator reported the sexual violation to the police.

Through this study, the need for services by survivors of defilement was noted through the high percentage of children who reported to both police and health facilities within 72 hours. Consequently, interventions are required to enhance the experience of child survivors in accessing services. It can be done by addressing social norms, related organizational factors, and individual behaviors to service use by engaging in multipronged approaches to mitigate the impact of sexual violence. This is backed up by a study conducted by Wangamati (2016) where through a case study of survivors it was established that systemic issues such as lack of infrastructure and provider knowledge gaps on existing policy frameworks serve as a barrier to the provision of quality care.

Additionally, from this study, there were notable variances in the time taken by survivors before reporting to a police station or hospital. This could be linked to either their lack of knowledge on where to report or the available services. This is similar to findings from a study by Muturia (2014), which linked delayed reporting of cases of sexual violence to formal sources with the stigma experienced by survivors and fear of disclosing their experiences. Delayed reporting also makes it difficult for providers to offer appropriate care and refer appropriately. For example, in Kenya, a lot of emphases has been placed on GBV response within 72-120 hours, as such survivors who report outside this timeline are most likely to miss out on care due to the lack of a defined service package. In a majority of instances, details of survivors who report outside these time frames are only captured in the general outpatient registers, contributing to

inaccurate service statistics on survivors attended to in a particular period. For instance, in Kenya, while the medical treatment package is offered within a 28-day period for HIV prevention and three months for counselling and repeat of HIV test, there is no defined period within which long term psychosocial support is provided. Nevertheless, the legal determination of cases of sexual violence in Kenya varies from one jurisdiction to the other based on caseloads within a court and prerogative of the magistrate to fast track the process.

Reporting channels for cases of sexual violence

In this study, 78 per cent of the cases were reported to the health facilities in comparison to those reported to the police and forwarded to the judiciary. A further review showed that the majority (84 %) of females reported to the police. In addition, children were more likely to report to both the police and the hospital. Reporting of cases of sexual violence remains an area of concern in most contexts. Previous studies show that factors which influence survivors reporting include not only their knowledge on where to report but also the stigma, fear of victimization, shame and costs involved in reporting to formal institutions-police and health facilities (Ullman and Peter-Hagene, 2014). The family has been identified as the first point of reporting for mediation before a case is reported to the police (McCleary-Sills et al., 2013). However, it was not possible to determine from the records review what informed the selection of the first point of reporting. Nonetheless, triangulation of data obtained through the interviews revealed the fear of negative health outcomes, such as HIV/STI infection and unwanted pregnancies as key motivators to survivors and their families opting to report to health facilities. In this study, uptake of counselling offered through the HIV care clinic stood at 2 per cent. This could be attributed to the practice where the counselling department services act as the last service

delivery point during the initial visit. Here the clients are counselled for trauma, prepared for investigative tests, and those found not to have reported to the police are guided accordingly.

In this study, it was noted that over 401 (n=983) survivors were attended to in the laboratory. Further triangulation of this finding with the qualitative data was undertaken in an effort to understand the reasons for this. According to providers interviewed, the reasons for laboratory tests included determining the clinical care to be provided, establishing the presence of infection and/or pregnancy in order to determine the survivors' eligibility for HIV and pregnancy prophylaxis, in addition to providing a basis for legal undertakings. It could also be assumed that there were gaps in documentation pertaining to the other survivors who received laboratory services. Reasons for this could be survivors opting not to access laboratory services either because the laboratory was not operational, or the long period of time spent in navigating through the other departments that caused delays till the laboratories were closed. This is comparable to the provision of the Anderson model, which stipulate how the organization of services serves as an enabler (or barrier) r to service utilization.

Weak data capture and reporting mechanisms for cases of sexual violence

The current study showed that survivors accessing health services are expected to navigate across different departments which are not always in close proximity to each other. At each of these points, providers are required to capture details of survivors and the services offered adequately. The findings showed a discrepancy of service uptake by the department as follows, laboratory (41%), outpatient department (26 %) and counselling (19 %). Data incompleteness was also noted during the review. In the present study, there were discrepancies

in the data maintained for survivors of sexual violence at each service delivery point. It appears that there is currently no mechanism to determine survivors' uptake of referrals within the health facility and outside the facility. However, these findings could also signal to there being gaps in reporting on the Kenya Health Information System (KHIS). Various factors could be linked to these gaps. Similar findings were obtained in a study I conducted in Kenya which revealed the inadequate supply of the requisite data tools by the Ministry of Health and police, and the lack of provider training on data capture mechanisms (Ajema, 2012). Further evidence from developed countries links the incompleteness of data to fear by providers of being called to present the evidence in court as well as lack of provider capacity in utilizing the existing tools (Davidson, 2001).

The lack of a standard identifier to enable tracking of survivors across the different departments was noted in this study. Providers are therefore required to capture three names from each survivor- first, second and surname in addition to indicating the sex and age of survivor in the PRC forms and PRC register for ease of identification. However, the current study brought to the fore gaps in the hospital. Only half of the records captured the three names, and 4 per cent of the entries bore similar names hence making it difficult to distinguish based on other missing entries such as age and type of sexual violence. In addition, 6 per cent did not indicate the age of the survivor, and 13 records did not indicate the date when the incident occurred. These data flows could compromise on the quality of services offered and follow up of cases to ensure justice is served. This is supported by a study conducted by Freeceero (2011) in Kenya which also found the lack of standardized tools, referral and follow up mechanisms. In the present study, there were discrepancies in the data maintained for survivors of sexual violence at

each service delivery point. It appears there is currently no mechanism to determine survivors' uptake of referrals within the health facility and outside the facility.

Poor and uncoordinated referral pathways

Out of the total of 983 hospital entries reviewed, a significant number of referrals were made to the laboratory (74%) and the least to the HIV clinic (2 %). Of those who took up counselling services, there was no documentation in place to show their uptake of the recommended follow-up sessions after the initial visit. It was also not possible to clearly establish uptake of referrals made to the police due to inconsistencies between the PRC, and P3 form, as well as the occurrence book register. However, a review of the counselling register revealed that over 80 per cent of survivors had been referred to the police, but it's unclear as to whether they accessed these services. The absence of standardized referral guidelines was noted in this study during the interviews with providers, therefore highlighting some perspectives on the current state of inconsistencies in the uptake of referrals. This is similar to findings generated from a study conducted in South Africa which showed a strong association between proper documentation of the sexual violence case and positive police and judicial outcomes (Holton et al., 2018). Hence, the chain of custody of evidence and accurate data capture is critical in sexual violence management.

6.3. Discussion and interpretation of the qualitative findings

This study also explored current practices in the delivery of Post Rape Care (PRC) services and enhanced understanding of Kenya's cross-sectoral coordination and referral mechanisms towards the delivery of functional PRC services in Kenya. To this end, data obtained from the qualitative interviews helped provide contextual realities as to what determines the reporting of

cases of sexual violence and gaps in the existing service delivery models. This section provides a discussion and interpretation of the above-mentioned key findings. It reflects on what the findings mean and how they compare to other existing evidence.

The discussion is presented in line with the factors outlined in the Anderson model with a focus on social determinants to reporting, formal and informal sources of support utilized, and pathways of care to be navigated by survivors.

Females and child survivors form the majority of the survivors

In this current study, more females than males reported cases of violence to health facilities and police stations. However, the results were based on the chain of evidence and custody records and not a population-based survey. Hence this is likely to be an under-estimate of the true sexual violence prevalence. This is commonly the case everywhere else (WHO, 2013). Both boys and girls are vulnerable to sexual violence, regardless of their socio-economic status. The results support data generated from a multi-country study that showed high levels of sexual violence against children. The study showed that approximately one in ten youth from Nigerian, Uganda and Zambia had experienced sexual violence (Nguyen et al., 2019). There is variance across countries of definitions of various forms of sexual violence, which poses challenges in the accurate comparison of results on the prevalence of rape, defilement, and other forms of sexual violence across different contexts. However, available research shows the importance of service statistics in building a case for resource allocation- both human, financial and infrastructural. This current study brings to fore the need for improved documentation of cases of sexual violence

reported across different sectors as a measure for enhancing multisectoral referral and coordination of actors.

Different predisposing factors influence survivors' choice of where to report

In the current study, the fear of negative health outcomes, such as HIV/STI infection and unwanted pregnancies were considered key motivators to survivors and their families opting to report to health facilities. In addition, some of the providers interviewed mentioned that some survivors choose to report to the police station anticipating legal action against the perpetrator. Further, the findings generated through this study show that reporting to the police is not always the survivor's decision to make, but rather a requirement placed on them by some health providers before they access health-related PRC services. For example, in this study, it was reported that survivors or their caregivers first consulted with their families or friends on whether or not to report and where to report. This is congruent to existing evidence where the family has been identified as the first point of reporting for mediation before a case is reported to the police (McCleary-Sills et al., 2013). Similar evidence from a study conducted in Kenya shows that child survivors do not have decision making power on whether to report or not. This is informed by the subordinate position in the community, resulting in them deciding to first report the incident to their parents or teacher before the case is forwarded to either the police or hospital (Shipman, 2016).

Available research also shows that reporting of cases of sexual violence would be expedited in cases where the perpetrator was well known to the survivor (Pattavina et al., 2016). This was, however, not found true in the context of this study as illustrated in my previous discussions on

the quantitative findings, whereby knowledge of perpetrators did not translate to speedy reporting of the incident.

Reporting to external family networks may only happen when the matter cannot be resolved by the family or community elders or where the survivor's choice is influenced by providers. In the current study, some providers were reported to compel survivors to report to the police before administering any treatment, as highlighted in Chapter five of the thesis. This practice is contrary to the National Guidelines on the management of sexual violence and the medical treatment regulations which provide access to treatment for all survivors (Ministry of Health, 2016). In the case of children, it is their family that determines whether or not to report, where when to report. The other motivators for this behavior include the relationship between the survivor and assailant, knowledge on where to first report an incident and the distance to be covered during service utilization. However, previous studies show that factors which influence survivors' manner of reporting include their knowledge on where to report, stigma, fear of victimization, shame and costs involved in reporting to formal institutions-police and health facilities (Ullman and Peter-Hagene, 2014). This resonates with findings of a study conducted in Kenya which revealed that families opt for community-based justice systems despite the existence of the SOA provisions (Shipman, 2016).

In seeking to understand this, and in line with the Anderson Model of health utilization, the predisposing factors to defilement include not only the age of the child but also their sex. The enabling factors, however, include the level of awareness in the community where the services are available, and the readiness of some caregivers to accompany their children to the facility.

These findings highlight the need for community members to be sensitized on the available services at each service delivery point and their right to access services without being compelled by any provider to report to the police. This will help promote timely reporting of sexual violence cases for prophylactic treatment and evidence collection.

Social determinants and influencers of reporting of cases

The current study found the pressure to preserve family honor as one of the reasons why cases of sexual violence are at times reported to the informal systems at the community level, which more often than not propagates local arbitration of such cases. Health providers interviewed in this study reported that shame and stigma associated with sexual violence contribute to non-reporting of cases more so to the formal justice sources of support. The findings corroborate the Ajzen (1991) theory of planned behavior which stipulates that one's perception of something--be it as something shameful or one that should not be hidden--influences their decisions based on prevailing norms and their intentions (Ajzen, 1991). In this study, the prevailing cultural practices were mentioned by respondents' as key inhibitors to reporting cases of sexual violence to the police. For example, they stated that in cases where the abuse is perpetrated by a family member, the first point of reporting is often to the clan elders. Secondly, in the context of this study, some survivors were cited not to report due to the shame and stigma associated with sexual violence. This, in turn, was found to contribute to the delayed reporting to health facilities within the 72 hours, and/or taking up referrals made by providers for the cases to be reported to the police.

The lack of trust in the police due to the allegations of corruption within the police force was also mentioned by both health providers, and in charges of shelter as one reason why people don't report cases of sexual violence. The police interviewed in this study highlighted the importance for the community to be sensitized on the available services and the need for timely reporting of cases. This mirrors findings from a study conducted in Mombasa Kenya which associated corruption with either delayed justice or total injustice (Kostelny et al., 2013).

The current study also established that reporting of cases of sexual violence is hampered, especially where the perpetrator is either related to the survivor or is a respectable member of the society. Evidence demonstrates that social norms play a key role in determining an individual's response to an issue (Savolainen, 2016). The normalization of the use of violence, including forceful sexual encounters in relationships and families has been documented to contribute to underreporting of these cases (Odwe et al., 2018). In Africa, heavy premiums have been placed on the importance of not shaming the family by not openly sharing some of the negative occurrences, such as rape and incest with outsiders. These findings are similar to those generated from other studies in LMICs that show that most cases of sexual violence perpetrated by heads of households or male providers are rarely reported for fear of the family not having someone to provide for them upon incarceration of the perpetrator (Wachter et al., 2018, Weiss, 2010, Weitzman et al., 2017). One case study in Nigeria revealed how delayed reporting of a case perpetrated on a 17-year-old resulted in a pregnancy and termination of the same due to cultural taboos around children born out of incest (Oseni et al., 2016).

Finally, in this study, it was reported that delayed reporting to the police is often not necessarily due to the police officer's incompetence's to handle such cases, but because some of the police do not subscribe social norms and cultural beliefs. In the two study sites, it was reported that cases of family-related violence are meant to be handled privately through informal sources. In addition, the police reported that at times people do not report to them cases where the assailant is known for fear of being jailed. The police are considered not respectful of the existing cultural practices, more so in instances where the case involves relatives. Cultural beliefs in some communities in Kenya consider it a taboo to discuss matters revolving sex with strangers, more so with those who do not belong to the community in question.

Enabling factors to client access and utilisation of services

The survivor health-seeking was in line with the health utilization model espoused in Chapter two of this thesis. The survivor's movement path is greatly influenced by whether they opt to disclose the violation to the triage health provider at the outpatient department or not. In this study, it was reported that most survivors opt to report to a health facility. However, the department they are referred to was dependent on the complaint they presented at the triaging and time of presentation. These findings are similar to results of a qualitative research study conducted in Kenya which presented difficulties experienced by survivors in disclosing sexual violence to providers for fear of either not being believed or being castigated for the abuse by providers (Munala et al., 2018). For instance, cases of rape and defilement reported within 72 hours are fast-tracked to the counselling and laboratory departments for HIV testing and

counselling so as to determine one's eligibility for PEP. Cases of indecent assault are referred for counselling only as such survivors are not eligible for prophylaxis. In contexts where the survivor disclosed to being HIV positive, they were upon being attended to at the OPD referred to the CCC for enrolment into HIV care.

Formal and informal source of support

In the current study, providers reported to the multiple pathways they had to follow in their pursuit of medical, legal and psychosocial support. This was also supported by the findings presented in Chapter Four of this thesis. The three most common pathways included (a) from household to community leaders; (b) from the community to police, and (c) from the community to the hospital. It was however noted by survivors and their caregivers that majority of cases are reported to the hospital due to the level of awareness created on available medico-legal services and/ or fear of negative outcomes associated with sexual violence. This is contrary to findings generated from a study conducted in Malawi that revealed police stations as the first point of reporting due to the positive and compassionate approach through which police officers attend to cases reported to them by community members (Chepuka, 2013).

However, within the health facility, it was noted that the referral pathways were not clearly defined as discussed in Chapter Two. The pathways of care, as presented in Chapter Two, were dependent on the date and time when a case was presented. It is noted in the review of the model of service delivery in place in the two hospitals sampled for this study that the daytime referral pathways differed from those employed at night when certain services such as counselling are not available. Survivors in this study reported they had to make more than one

trip in between the hospital and police stations before being issued with duly filled in P3 and PRC forms. These findings were backed up by the quantitative data review undertaken in this study, where over seven service delivery points in the facility were found to offer components of the PRC services. In this study, survivors reported having incurred delays in shuttling between the different offices. In addition, this study also pointed out that not all services are available 24 hours, seven days a week, hence missed opportunities for care, especially counselling and laboratory services which are only offered within stipulated timeframes in most hospitals. This practice is traumatizing. Similar results were found in another study that I undertook which demonstrated that the complex web of referrals as a contributor to the lack of uptake of referrals given at each SDP (Ajema et al., 2015). In that study, survivors reported to not only being attended to by different providers but being forced to narrate their complaint at each visit, in addition to not being given the P3 form within the day of reporting. This study highlights the need for facilities to develop a PRC service delivery model reduces survivor movements from one SDP to another and time spent queuing at each service area. The current service delivery model increases exposure to secondary trauma by survivors and their caregivers. This is due to the current practice in Kenya where different providers are involved in the provision of care, and it is not guaranteed that a survivor will be attended to by one provider. The end result is that they have to repeat their story every time they access care.

This current study revealed that not all survivors reported to the hospital. Existing evidence shows that only 7 per cent of cases seek support from formal support systems (Palermo et al., 2013). Some of these barriers as identified in the current study include lack of trust in some providers due to the existing culture of impunity, vast distances to be covered in search of care,

the protracted amount of time spent moving from one department to the other to receive care, and lack of clarity of the referral pathways to be followed and costs involved.

Findings from this study show instances where survivors and their families place more emphasis on seeking informal sources of support. These include their immediate relatives or village elders. This is documented in a Malawian study which showed that formal sources were only considered an option in instances where local mediation of cases failed (Chepuka, 2013). A study conducted in Kenya highlighted the clash between the formal legal and community level alternate forms of justice for survivors. The Kenyan study revealed that contrary to provisions of the Sexual Offences Act No 3 of 2006, with regards to punishment to be meted to perpetrators upon conviction, the village elders hold so much power including the power to arbitrate cases of sexual violence and prescribe the compensations to be given to the survivor by the perpetrator (Shipman, 2016). The literature reviewed in this study collaborates that indeed in most communities, there is more reliance on informal rather than formal sources for help. This implies women would only seek help from formal sources of help when abuse is perceived as severe, and there is no help forthcoming from the informal sources (Abeya, 2012).

Based on the findings, there is a need for these barriers to be addressed through approaches which enhance collaboration mechanisms between the formal and informal response mechanisms (Freccero et al., 2011). Some of these opportunities in Kenya include capacity building initiatives that bring together providers from different sectors; development of common indicators to be measured across different sectors, and sensitizing community leaders on the existing legal frameworks that deter local arbitration of cases of sexual violence. The role

of the informal justice system in enhancing reporting of cases of sexual violence to both the hospital and the police in Kenya should be explored further.

In this study, it was established that follow up mechanisms of survivors within the community and upon referral to other services are not well defined or structured. Health providers cited a lack of standard tracking tools. As a result, the onus of following through with the different appointments given rests with the survivor.

In a study conducted by Muthoni (2019), individual help-seeking behavior was influenced by their perception of how affordable, and convenient a service was. The results corroborate with those generated in this study, where the author assumes that distance to various points of care from the community, the layout of services at the health facilities, and time that is taken to navigate through the referral web are barriers to service uptake by survivors of sexual violence. However, the failure by service providers to document services offered, referrals made, and follow-ups done for survivors were due to lack of standardized referral tools. The condition makes it challenging to clearly determine the contributory factors to low uptake of trauma counselling and mismatch between the cases handled at different service delivery points.

6.4. A personal reflection on the findings

I, in this section, share my own reflections as informed by the findings presented in Chapters Four and Five.

Types of sexual violence reported: The results presented in this study as obtained through service statistics show that sexual violence affects both males and females. Given the hidden

nature of sexual violence and stigma associated with it, most countries derive data on the magnitude of sexual violence from data that is captured from survivors who choose to report to formal sources. In Kenya, most data on sexual violence is generated through the hospital and police data. Hence the reason why this study opted to rely on these data source to determine the prevalent forms of sexual violence reported. This study did not, however, set out to explore the prevalence of sexual violence in the study sites. It focused on the numbers reporting for care in line with the study objectives and the theoretical model applied in this study on seeking to obtain information on the utilization of services by survivors.

Weak implementation of policies: The literature review undertaken as part of this study indicated the existence of several policy frameworks and legal statutes towards response to sexual violence exist in Kenya (Ministry of Health, 2012; Ministry of Health, 2016; MoH, 2014; TFSOA, 2013). In my own reflection, these policies have, however, either not been widely disseminated to all services providers, or measures have not been put in place to assess the quality of service provision against these policy frameworks. The findings of this study resonate with those from a study previously conducted in Kenya which linked non-reporting of cases of sexual violence to the police with heightened levels of corruption by the officers, compromised investigative procedures and instances where fear of reprisal from perpetrators was a hindrance (Ofwona, 2015). From the existing literature, lack of training of health providers has been cited as a contributory factor as to why services were not offered or documented as per the set guidelines. In the context of my work in this field and constantly engaging with health providers, it has emerged that some them evade handling cases of sexual violence for fear of being required to present in court yet they are not compensated financially by either the hospital or

courts. Lack of adequate provider training was also found by another study in Kenya (Munala et al., 2018).

The study findings show the need for coordinated multi-sectoral referral mechanisms for survivors. The Kenya multisectoral SOPs on the prevention and response to sexual violence provides for the referral pathways to be applied by each sector (TFSOA, 2013). A coordinated sexual violence response call for the setting up of multisectoral working groups and Court User Committees (CUCs) as platforms to enhance adaption of national sexual violence policies to County contexts, informing financial allocation towards GBV response and enhancing mechanisms for data sharing among the different players.

Need for efficiency in service delivery: In this study, the organization of services and time taken to access services is an element of concern. There is a need for models of care that facilitate survivor ease of movement within health facilities and reduce the waiting time before accessing services. Evidence shows the gendered nature of health-seeking and that women and girls form the majority of consumers of health services. In the context of sexual violence, existing evidence confirms that the majority of survivors are women and girls (Juvrud and Rennels, 2017, Heise et al., 2019). Looking at the gender domain of decision making and time use; it becomes imperative for services to be modelled against this. Failure to which women and girl's decision making on taking up health services will be affected in such a way that they would opt not to report to health facilities to avoid 'wasting' time at the expense of fulfilling their duties.

6.5. Contribution to the body of knowledge

Societal norms influence service utilization. The Andersen model, therefore, provides a mechanism that allows program implementers addressing sexual violence to clearly identify how societal norms influence an individual's utilization of services. The influence of community structures in addressing GBV cannot be ignored. This is as presented in the qualitative findings of this study, which upon triangulation with the quantitative data, provide insights into reasons why some survivors did not report for services within the stipulated time frame. These findings are compared to a study conducted in Ethiopia on the uptake of the required minimum of four ANC sessions, in which only 15 % of women attended four or more sessions (Tesfaye et al., 2018). Predisposing factors such as wealth index, marital status and partner's attitude were linked with this health utilization behavior. The findings generated through this study by Gatuguta (2018) also indicate that community norms influence service use and should be clearly addressed in order to strengthen the appropriate reporting of cases.

The Anderson framework presented in chapter three and briefly discussed in this section shows how this model has helped to expound on the determinants for utilization of services by survivors of sexual violence. This is the first study in Kenya that does a comparative analysis of sexual violence cases handled across sectors, by not only analyzing the service record statistics but also interviewing survivors so that their voices and experiences in the utilization of the PRC services are documented. The findings of this study clearly demonstrate that the utilization of services does not solely depend on the survivors' choice, but rather on the prevailing social norms, and cultural practices that may hinder reporting to formal sources of support. In addition, while evidence exists to demonstrate the high reported cases of sexual violence among children, this study through the use of Anderson model calls for further research in the area of children

and their guardians to better understand child-specific predisposing factors to reporting. Evidence already exists in Kenya as regards the responsiveness of the existing health services to child survivors. However, gaps still exist on the needs of children across the different service delivery points to help inform their ability to contribute to decision making on their health-seeking behavior. This study provides a basis by which different stakeholders can develop an agenda on key areas that impede an effective GBV response.

From a policy perspective, this study helps show that the existence of policy frameworks on sexual violence in Kenya does not necessarily translate to a strengthened sexual violence response. The study also reveals the need for indicators to measure effective referral and linkage across sectors. Sexual violence programmatic interventions and government departments ought to put in place mechanisms to oversee the quality of data capture and its utilization. This calls a deliberate and critical reflection being made to the provider's experiences in service provision and documentation of evidence, and survivor experiences with care-seeking. Improved multisectoral handling of sexual violence required the roll-out of Quality Improvement (QI) mechanisms for post rape care services.

The study findings resonate with previous research that highlighted the need for multisectoral engagement in GBV response (Kilonzo et al., 2009; 2013).

6.6. Study limitations

The mixed methodological approach has value in one set of data being able to complement the other and add additional insights. However, the research showed that it was not possible to follow individual survivors prospectively, through the different pathways of care from the health

to the court system, examining their experience of care along the way. It would not have been feasible to use a prospective approach because the length of time it takes that varies in the care and referral of survivors from one sector to another. Further research following a small number of individual cases of sexual violence across the different sectors would be of value for an additional understanding of the survivor movement along the continuum of care.

By recruiting only survivors (and caregivers of those aged below 18 years) accessing health-related PRC services during the study period, experiences of those who had also navigated their way through the police and court were excluded from this study. While including survivors who had experiences across the different sectors would have added to the body of knowledge on the referral pathways, it would have burdened the research in terms of time and financial resources which were not available at the onset of the study. None of the survivors recruited into the health facility had reported to the police. It was noted that identification and recruitment of survivors at the police station would have posed an ethical dilemma given the nature of service layout at the police reporting desk which is accessible to the public in addition to being manned by police officers not trained on GBV.

As the nature of qualitative research is to interview purposively selected key individuals, small samples are common in order to provide in-depth insights and findings that are not intended to be generalizable to personnel in all health facilities, police stations and courts in Kenya. There is a need for further research on the coordination mechanisms and practices governing the reporting of cases of sexual violence in more urban and rural communities in

Kenya. This study did not exhaustively look at the existing community reporting mechanisms, which would differ from community to community because of time and budget constraints.

This study relied on data captured through the designated forms in use at the health facility and police station. This review did not account for any other mechanisms used at the institutional level to ascertain uptake of the referrals by survivors of sexual violence. This could either be in the form of handwritten notes to specific referral points or through direct phone calls in case of referrals. This practice thus limits the study's ability to draw conclusions on referral uptake by survivors.

Chapter 7 : CONCLUSION AND RECOMMENDATIONS

The findings obtained through this study show the different pathways taken by survivors in reporting sexual violence and seeking care, the approaches used by providers across different sectors to care for and refer survivors, and information on the quality of data captured. They, therefore, show the flow of survivors from one department and/or sector to another. It reviews actual care and referral practices against the provisions within the Kenyan National Guidelines on the management of sexual violence. The study also highlights strengths and gaps in coordination and linkage across the different sectors. It provides insights from a comprehensive group of care stakeholders and survivors on sexual violence experiences and the workings of the system of care and referral.

However, in the context of countries like Kenya where health facilities do not have a budgetary provision for such follow up measures, I recommend for advocacy engagements to be undertaken with the hospital management to institutionalize sexual violence follow up mechanisms through provider training on effective referrals and linkages, budgetary allocation for home visits by community-owned resource persons and phone follow-up by health providers. This, however, is an area that warrants further research to help inform the implementation of a client-centered follow-up mechanism.

The results of this study call for the involvement of community structures and leaders in the development of multisectoral referral and coordination mechanisms for survivors. There is a need for further research to establish the key considerations to be integrated into a community sexual violence reporting mechanisms that are in the best interest of the survivor in addition to

enhanced timely identification, referral and follow up of survivors across various levels of opportunity.

Data management is key to the determination of the quality of care offered to survivors. While the Kenya health information system has specific health focussed indicators, there lacks a holistic gender-based violence information system in Kenya to facilitate collation of data on key indicators as obtained from different sectors. Data are needed not only to describe the problem at hand but also help in service access and utilization over time. This study, therefore, recommends measures to be put in place towards the development of multi-sectoral Gender-Based Violence Management Information System (GBVIMS).

Therefore, the health system needs to include violence indicators in the Health Management Information System (HMIS) and in other Ministries. These indicators need to be common across disciplines (health care, criminal justice, social services, development partners, etc.). There is also a need for policies and practices that protect against the misuse of data and ensure privacy.

Overall, the study calls for strengthening multi-sectoral data capture and referral system to help track survivors attended to, in an effort to build a case towards the requisite investments for GBV response.

7.1. Future research questions

This study recommends further research on the following:

- The extent to which adaption of an electronic GBV integrated management systems across sectors may enhance referrals of survivors. The Gender-Based

Violence Information and Management System (GBVIMS) has mostly been tested in emergency settings due to multiple actors involved in response to GBV within these settings. However, no study can be undertaken on this in Kenya in non-emergency settings. In addition, further investigation of the applicability of this model in non-conflict settings is required.

- What mechanism is required to facilitate linkage, follow up and referral of cases between the formal and informal support system without propagating local arbitration of cases, or compromising a survivor's identity? In addition to determining the feasibility of these mechanisms in more rural, urban and peri-urban settings.
- What would be the best multisectoral sexual violence response model for child survivors of sexual violence?

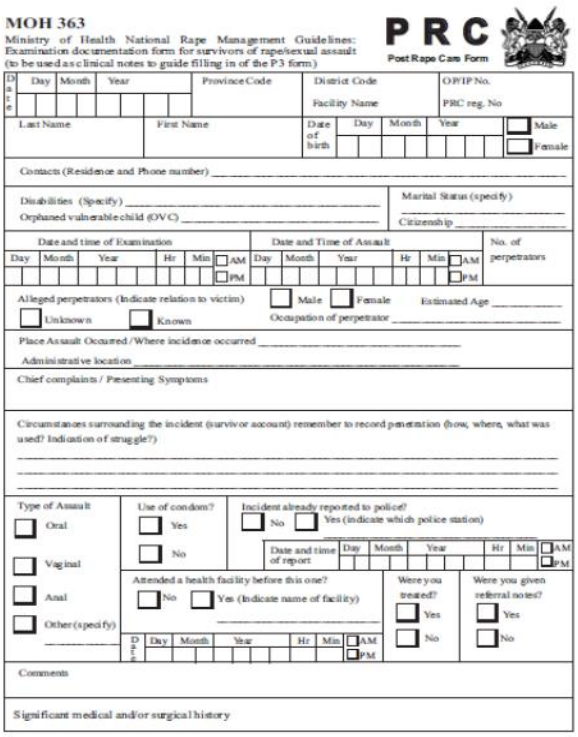
APPENDICES

Appendix 1: A description of sexual offences in Kenya

Sexual Offence	Description of the offence
Rape	Under section 3 of the Act, a person commits rape if: a) S/he intentionally & unlawfully commits an act which causes penetration with his/her genital organs; b) The other person does not consent to the penetration; or c) The consent is obtained by force or by means of threats or intimidation of any kind.
Sexual Assault	Under section 5 of the Act, sexual assault occurs when a person unlawfully penetrates the genital organs of another with: a) Any part of the body of that or another person; or b) An object manipulated by that or another person; *except where such penetration is carried out for proper & professional hygienic or medical purposes.*
Indecent act (Ranney et al., 2011b)	An indecent act is that which causes: a) Any contact between the genital organs of a person, his/her breasts & buttocks with that of another person; b) Exposure to or display of any pornographic material to any person against his/her will but does not include an act which causes penetration. Under s.6 of the Act, any person who intentionally & unlawfully compels, induces or causes another person to engage in an indecent act is guilty of an offence.
Indecent act (2)	It is an offence for a person to intentionally commit rape or an indecent act with another within view of: • family member/s, • a child, or • a person with mental disabilities
Defilement	Defilement is covered under s.7 of the Act. This offence is committed when a person commits an act which causes penetration with a child. Note: It is a defense to a charge of defilement if: a) It is proved that such child, deceived the accused person into believing that s/he was over 18 at the time the alleged offence was committed; and b) The accused reasonably believed that the child was over 18. Child sexual offenders – where a child is charged with an offence under the Act they are sentenced as per the provisions

	of the Children's Act.
Indecent act with a child	Under s.11 of the Act, any person who commits an indecent act with a child is guilty of an offence & liable to imprisonment for a minimum of 10 years. Note: It is a defense to a charge of defilement if: a) It is proved that such child, deceived the accused person into believing that s/he was over 18 at the time the alleged offence was committed; and b) The accused reasonably believed that the child was over 18.
Promotion of sexual offences with a child	Under s.12 of the Act, a person including a legal entity (e.g. company) who: a) Manufactures or distributes any article that promotes/is intended to promote a sexual offence with a child; or b) Who supplies or displays to a child any article which is intended to be used in the performance of a sexual act with the intention of encouraging or enabling that child to perform such sexual act is guilty of an offence.
Child prostitution	Under s.15 of the Act: the offence is committed by any person who: a) Knowingly permits any child to remain in any premises, for purposes of causing such child to be sexually abused; b) Acts as a procurer of a child for the purposes of sex; c) Induces a person to be a client of a child for sex or indecent exhibition; d) Takes advantage of his influence over, or relationship to a child, to procure the child for sex or indecent exhibition; e) Threatens or uses violence towards the child to procure the child for sex or indecent exhibition; f) Intentionally/knowingly owns, leases, rents, manages, occupies or has control of property used for purpose of commission of sexual offences with a child by any person; g) Gives monetary consideration, goods, other benefits or any other form of inducement to a child/his parents with intent to procure the child for sex or indecent exhibition;
Trafficking for sexual exploitation	Under s.18 any person who intentionally or knowingly arranges or facilitates travel within or across the borders of Kenya by another & either: a) Intends to do anything to or in respect of the person during or after the journey which will constitute a sexual offence under this Act; or b) Believes that another person is likely to do something to or in respect of another person that will constitute such sexual offence,
Incest	The SOA recognizes that it can be committed by either men or women. It's an indecent act/an act that causes penetration done with a relative. Note:

	Upon conviction, the accused is divested of all authority over the victim under s.114 orders (Children's Act)
Sexual harassment	Is committed by any person, who: • Being in a position of authority, or holding a public office; • Persistently makes any sexual advances which s/he knows or has reasonable grounds to know, are unwelcome. Note: It's necessary to prove: a) The submission or rejection by the person to whom advances/requests are made is intended to be used as a basis of employment/promotion or to receive a public service. b) Such advances/requests have the effect of interfering with the alleged victim's work or educational performance or denial of a public service due to the victim.



MOH 363

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

PRC Post Rape Care Form

Date: Day | Month | Year | Province Code | District Code / Facility Name | OPD/IP No. / PRC reg. No

Last Name | First Name | Date of birth: Day | Month | Year | Male | Female

Contacts (Residence and Phone number) _____

Disabilities (Specify) _____ | Marital Status (specify) _____

Orphaned vulnerable child (OVC) _____ | Citizenship _____

Date and time of Examination: Day | Month | Year | Hr | Min | AM | PM

Date and Time of Assault: Day | Month | Year | Hr | Min | AM | PM | No. of perpetrators

Alleged perpetrators (Indicate relation to victim) ☐ Male ☐ Female Estimated Age _____

☐ Unknown ☐ Known Occupation of perpetrator _____

Place Assault Occurred / Where incidence occurred _____

Administrative location _____

Chief complaints / Presenting Symptoms

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

_____

_____

_____

Type of Assault: ☐ Oral ☐ Vaginal ☐ Anal ☐ Other (specify) _____

Use of condom? ☐ Yes ☐ No

Incident already reported to police? ☐ No ☐ Yes (indicate which police station) _____

Date and time of report: Day | Month | Year | Hr | Min | AM | PM

Attended a health facility before this one? ☐ No ☐ Yes (Indicate name of facility) _____

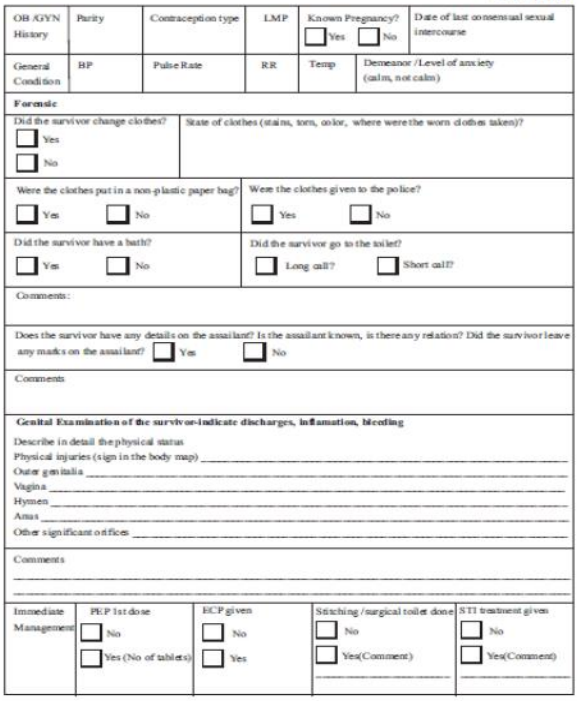
Date: Day | Month | Year | Hr | Min | AM | PM

Were you treated? ☐ Yes ☐ No

Were you given referral notes? ☐ Yes ☐ No

Comments

Significant medical and/or surgical history



MOH 363

OB/GYN History: Parity | Contraception type | LMP | Known Pregnancy? ☐ Yes ☐ No | Date of last consensual sexual intercourse

General Condition: BP | Pulse Rate | RR | Temp | Demeanor / Level of anxiety (calm, not calm)

Forensic

Did the survivor change clothes? ☐ Yes ☐ No

State of clothes (stains, torn, color, where were the worn clothes taken)?

Were the clothes put in a non-plastic paper bag? ☐ Yes ☐ No

Were the clothes given to the police? ☐ Yes ☐ No

Did the survivor have a bath? ☐ Yes ☐ No

Did the survivor go to the toilet? ☐ Long call? ☐ Short call?

Comments:

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

Comments

Genital Examination of the survivor-indicate discharges, inflamation, bleeding

Describe in detail the physical status

Physical injuries (sign in the body map) _____

Outer genitalia _____

Vagina _____

Hymen _____

Anus _____

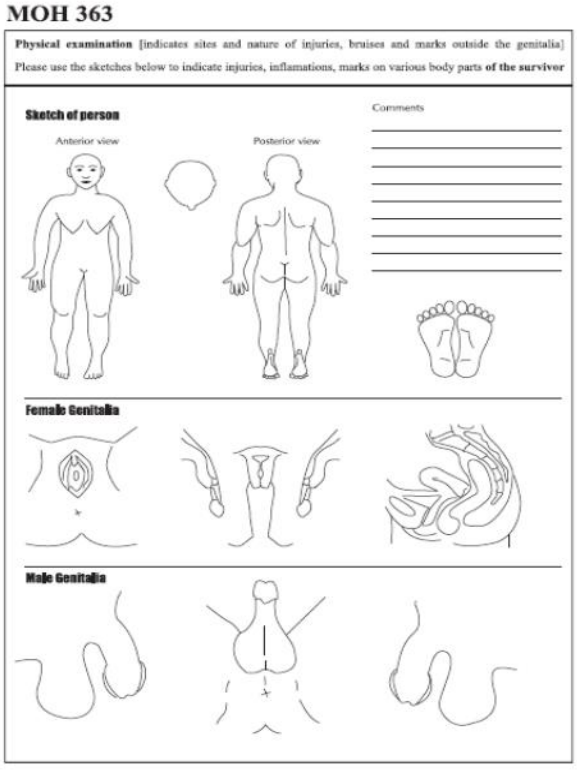
Other significant orifices _____

Comments

_____

_____

Immediate Management	PEP 1st dose	ECP given	Stitching / surgical toilet done	STI treatment given
	☐ No ☐ Yes (No of tablets)	☐ No ☐ Yes	☐ No ☐ Yes(Comment)	☐ No ☐ Yes(Comment)



MOH 363

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

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

Sketch of person

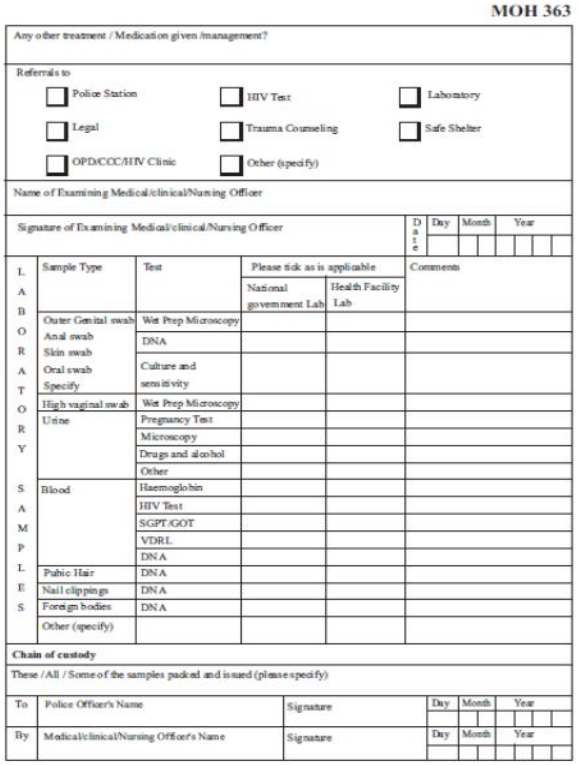
Anterior view | Posterior view

Comments

_____

Female Genitalia

Male Genitalia



MOH 363

Any other treatment / Medication given /management?

Referrals to

☐ Police Station ☐ HIV Test ☐ Laboratory

☐ Legal ☐ Trauma Counseling ☐ Safe Shelter

☐ OPD/CCC/HIV Clinic ☐ Other (specify)

Name of Examining Medical/clinical/Nursing Officer

Signature of Examining Medical/clinical/Nursing Officer | Date: Day | Month | Year

LABORATORY SAMPLES	Sample Type	Test	Please tick as is applicable: National government Lab	Health Facility Lab	Comments
	Outer Genital swab / Anal swab / Skin swab / Oral swab / Specify	Wet Prep Microscopy			
		DNA			
		Culture and sensitivity			
	High vaginal swab	Wet Prep Microscopy			
	Urine	Pregnancy Test			
		Microscopy			
		Drugs and alcohol			
		Other			
	Blood	Haemoglobin			
		HIV Test			
		SGPT/GOT			
		VDRL			
		DNA			
	Pubic Hair	DNA			
	Nail clippings	DNA			
	Foreign bodies	DNA			
	Other (specify)				

Chain of custody

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

To	Police Officer's Name	Signature	Day / Month / Year
By	Medical/clinical/Nursing Officer's Name	Signature	Day / Month / Year

Appendix 2: National post rape care form

POST RAPE CARE FORM (PRC)

PRC FORM IS **NOT** FOR SALE

PART B

PSYCHOLOGICAL ASSESSMENT

MOH 363

Part B is intended to assess the mental status of a client in order to be able to offer holistic care. This should inform the management and subsequent follow up of the client and hence should be filled in at presentation.

Psychological assessment should be done by trained health care providers including Medical Officers, Nurses, Clinical Officers, Psychiatrists, Psychological Counselors and Medical Social Workers duly recognized by the Ministry of Health.

The Medical Officers and other persons designated by law as expert witnesses in court (Nurses and Clinical Officers) should be the ones to sign off both the Part A and B of the PRC form.

General appearance and behavior
Note appearance (appear older or younger than stated age), gait, dressing, grooming (neat or unkempt) and posture.

Rapport
Easy to establish, initially difficult but easier over time, difficult to establish.

Mood
How he/she feels most days (happy, sad, hopeless, euphoric, elevated, depressed, irritable, anxious, angry, easily upset).

Affect
Physical manifestation of the mood e.g. labile (emotions that are freely expressed and tend to alter quickly and spontaneously like sobbing and laughing at the same time), blunt/ flat, appropriate/ inappropriate to content.

Speech
Rate, volume, speed, pressured (tends to speak rapidly and frenziedly), quality (clear or mumbling), impoverished (monosyllables, hesitant).

Perception
Disturbances e.g. Hallucination, feeling of unreality (corroborative history may be needed to ascertain details)

Thought content
Suicidal and Homicidal Ideation (Ideas but no plan or intent; clear/unclear plan but no intent; ideas coupled with clear plan and intent to carry it out); any preoccupying thoughts.

Thought process
Goal-directed/ logical ideas, loosened associations/ flight of ideas/ illogical, relevant, circumstantial (drifting but often coming back to the point), ability to abstract, perseveration (constant repetition, lacking ability to switch ideas).

(For children use wishes and dreams, and art/ play therapy to assess the thought process and content.
-Through drawing and play (e.g. use of toys). Allow the child to comment on the drawing and report verbatim.

-Assess the unconscious world of the child by asking about feelings e.g. ask the child to report the feeling that he/she commonly experiences and ask what makes him/her feel that way

Cognitive function-

a. Memory: Recent memory, long-term and short term memory (past several days, months, years).

b. Orientation: to time, place, person i.e. ability to recognize time, where they are, people around e.t.c.

c. Concentration: ability to pay attention e.g. counting or spelling backwards, small tasks

d. Intelligence: Use of vocabulary (compare level of education with case presentation; above average, average, below average).

e. Judgment: Ability to understand relations between facts and to draw conclusions; responses in social situations.

Insight level: Realizing that there are physical or mental problems; denial of illness, ascribing blame to outside factors; recognizing need for treatment (Indicate whether insight level is; present, fair, not present)

Recommendation following assessment	**Referral point/s**

Referral uptake since last visit e.g. other medical services, children's department, police, legal aid, shelter e.t.c.

By	Name of Examining Officer (Doctor/Nurse/Clinical officer)	Signature	Day	Month	Year
To	Police Officer's Name	Signature	Day	Month	Year

Appendix 3: Rape trauma counselling form

RAPE TRAUMA COUNSELING DATA FORM

Sex			**Has the client reported to the police?**			0 No	1 Yes
1 Male	2 Female					If not, name reason(s)	
Age (years)			0 No	1 Yes			
			If not, name reason(s)			**2nd Visit**	
Education			**a) Is the client willing to report to the police?**			a) Disclosure of SV	
0 None			0 No	1 Yes		0 No	1 Yes
1 Primary			If not, name reason(s)			b) Disclosure HIV results	
2 Secondary			**Client referred from?**			0 No	1 Yes
3 Post Secondary/Technical			1 VCT services	2 Police stations		c) PEP adherence	
Marital Status			3 Health Facilities	9 Other		0 No	1 Yes
0 Never	1 Married		**Was the 1st dose of PEP administered?**			If not, name reason(s)	
2 widowed	3 Separated/Divorced		0 No	1 Yes		d) Still taking PEP	
Type of assault			If not, name reason(s)			0 No	1 Yes
1 Penile anal rape	2 Penile vaginal rape		1 Presented after 72 hours	2 Client declined		**3rd Visit**	
3 Use of objects in vagina			9 Other			Is disclosure done so far ?	
4 Use of objects in anus			**Was EC administered?**			0 No	1 Yes
9 Other			0 No	1 Yes	2 N/A	Comments	
Client seen			If not, name reason(s)			**4th Visit**	
1 Individual	2 With partner		**Did client know HIV status before the assault?**			Comments	
3 With guardian/parent	4 With friend/relative					**5th Visit**	
9 Other			0 No		1 Yes	HIV Test done	
Services required by client			If Yes,			0 Negative	1 Positive
Was the PRC 1 form filled?			0 Negative		1 Positive	Disclosure of SV	
0 No	1 Yes		**1st Visit**			0 No	1 Yes
If not, name reason(s)			a) HIV test done			Disclosure of HIV Results	
			0 No	1 Yes	2 Declined	0 No	1 Yes
			If Yes,	0 Negative	1 Positive	Pregnancy Test done	
Who is the assailant?			b)Pregnancy Test done			0 No	1 Yes	2 N/A
						Results	0 Negative	1 Positive
			0 No	1 Yes	2 N/A	**Comments**	
0 Known	1 Unknown		Results	0 Negative	1 Positive		
If known, specify relationship			c) Disclosed SV				
			0 No	1 Yes			

Appendix 4: Kenya police medical examination (P3) form

This P3 Form is free of charge

THE KENYA POLICE P3

MEDICAL EXAMINATION REPORT

PART 1-*(To be completed by the Police Officer Requesting Examination)*

From_____Ref_____

_____Date_____

To the_____Hospital/Dispensary

I have to request the favour of your examination of:-

Name_____Age_____(If known)

Address_____.

Date and time of the alleged offence_____

Sent to you/Hospital on the_____20_____

Under escort of_____

and of your furnishing me with a report of the nature and extent of bodily injury sustained by him/her.

Date and time report to police_____

Brief details of the alleged offence

_____

_____

_____

_____

Name of Officer Commanding Station Signature of the Officer Commanding Station

PART 11-MEDICAL DETAILS - ***(To be completed by Medical Officer or Practitioner carrying out examination)***

*(Please type **four** copies from the original manuscript)*

SECTION "A"-THIS SECTION MUST BE COMPLETED IN ALL EXAMINATIONS

Medical Officer's Ref. No._____

1. State of clothing including presence of tears, stains (wet or dry) blood, etc.

_____

_____

2. General medical history (including details relevant to offence)

_____

_____

_____

_____

3. General physical examination (including general appearance, use of drugs or Alcohol and demeanour)

_____

_____

This P3 Form is free of charge

SECTION "B"- TO BE COMPLETED IN ALL CASES OF ASSAULT INCLUDING SEXUAL ASSAULTS

COMPLETION OF SECTION "A"

1. Details of site, situation, shape and depth of injures sustained:-

a) Head and neck

_____

_____

b) Thorax and Abdomen.

_____

_____

c) Upper limbs

_____

_____

d) Lower limbs

_____

_____

2. Approximate age of injuries (hours, days, weeks)

3. Probable type of weapon(s) causing injury

4. Treatment, if any, received prior to examination

5. What were the immediate clinical results of the injury sustained and the assessed degree, i.e.' harm", or' grievous harm".*

DEFINITIONS:-

"Harm" Means any bodily hurt, disease or disorder whether permanent or temporary.

"Maim' means the destruction or permanent disabling of any external or organ, member or sense

"Grievous Harm" Means any harm which amounts to maim, or endangers life, or seriously or permanently injures health, or which is likely so to injure health, or which extends to permanent disfigurement, or to any permanent, or serious injury to external or organ.

Name & Signature of Medical Officer/Practitioner_____

Date_____

Appendix 5: Approval letters for the study

5.1 Approval from Thika County

MINISTRY OF EDUCATION and technology

Telephone (067) 31398 / 31272 (D.L)
OFFICE
FAX: (067) 31272
When Replying please quote

DISTRICT EDUCATION

THIKA WEST DISTRICT
P.O. BOX 262,
THIKA

THK/ADM/MIS/Vol.II/335

25th February 2014

TO WHOM IT MAY CONCERN

Re: Research Authorization
Carolyne Ajema Agesa

The bearer of this letter Carolyne Ajema Agesa has been authorized to carry out research on "**Utilization of a multi-sectoral approach in strengthening cross-sectoral referrals of survivors of sexual violence from the health sector in Kenya.**" for a period ending **28TH, February, 2014.**

Kindly assist her.

Signature Removed

(J.N. NJARAMBA)
FOR: DISTRICT EDUCATION OFFICER
THIKA WEST

5.2: Approval from Thika County Commissioner

OFFICE OF THE PRESIDENT
MINISTRY OF INTERIOR AND COORDINATION OF NATIONAL GOVERNMENT

Telegrams: "DISTRICTER" Thika
Telephone: Thika 067-21222 and 21884
Fax: 067 - 31199

P.O Box 128-01000

THE DEPUTY COUNTY COMMISSIONER
THIKA WEST SUB COUNTY
THIKA

When replying please quote

Ref:CORR.3/4/VOL.VIII/170

Date: 25th February, 2014

Carolyne Ajema Agesa
University Of Cape Town
SOUTH AFRICA

RE: RESEARCH AUTHORIZATION

Following your request to carry out research in thika west Sub County on ***"utilization of a multi-sectoral approach in strengthening cross-sectoral referrals of survivors of sexual violence from the health sector in Kenya"***,I am pleased to inform you that you have been authorized to carry out the research for a period ending 28th march 2014.

The purpose of this letter is therefore to introduce you to the concerned institutions to accord you the necessary assistance.

Signature Removed

FOR: DEPUTY COUNTY COMMISSIONER

THIKA WEST SUB COUNTY

C:

THE MEDICAL OFFICER OF HEALTH – THIKA

THE DISTRICT EDUCATION OFFICER – THIKA

ASSISTANT COUNTY COMMISSIONER – MUNICIPALITY DIVISION.

5.3: Approval from Nakuru County Ministry of Education

MINISTRY OF EDUCATION

Telegrams: "EDUCATION", R.V.P.
Telephone: 051-2216917
When replying please quote

Ref. No. EDL/NKU/GEN/4/1/21/116

COUNTY DIRECTOR OF EDUCATION
NAKURU COUNTY
P. O. BOX 259,
NAKURU.

26TH February, 2014

TO WHOM IT MAY CONCERN

RE: RESEARCH AUTHORIZATION
CAROLYNE AJEMA AGESA – UNIVERSITUY OF CAPE TOWN

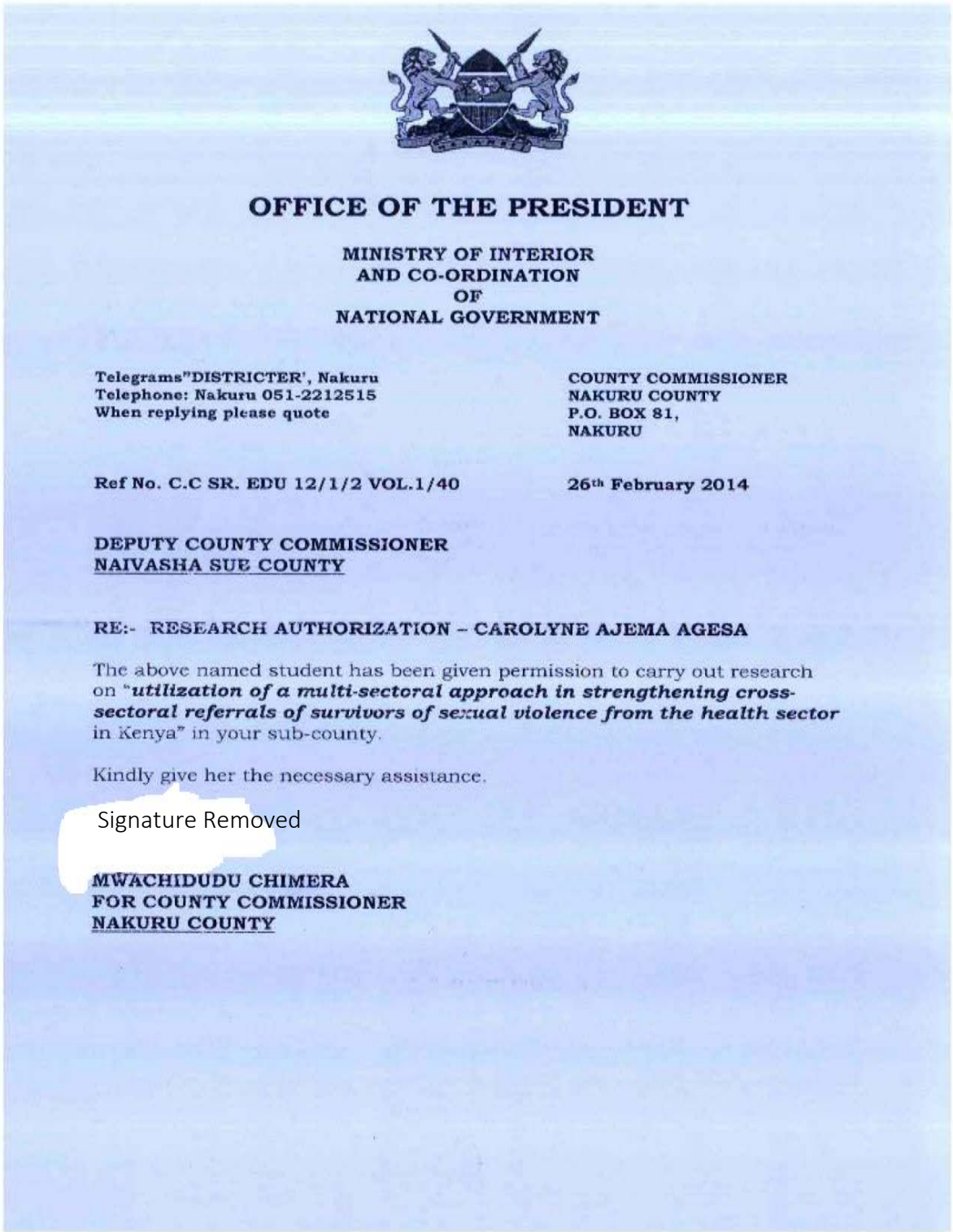
The above named is hereby given authority to undertake research on **"Utilization of a Multi-sectoral approach in strengthening cross-sectoral referrals of survivors of sexual violence from the health sector in Kenya"**. The research will be for a period ending 28th February, 2014.

Assistance given to her will be highly appreciated.

Signature Removed

D. M. WANGORU
FOR: COUNTY DIRECTOR OF EDUCATION
NAKURU COUNTY

5.4: Approval from Nakuru county commissioner



OFFICE OF THE PRESIDENT

MINISTRY OF INTERIOR
AND CO-ORDINATION
OF
NATIONAL GOVERNMENT

Telegrams"DISTRICTER', Nakuru
Telephone: Nakuru 051-2212515
When replying please quote

COUNTY COMMISSIONER
NAKURU COUNTY
P.O. BOX 81,
NAKURU

Ref No. C.C SR. EDU 12/1/2 VOL.1/40

26th February 2014

DEPUTY COUNTY COMMISSIONER
NAIVASHA SUE COUNTY

RE:- RESEARCH AUTHORIZATION – CAROLYNE AJEMA AGESA

The above named student has been given permission to carry out research on "***utilization of a multi-sectoral approach in strengthening cross-sectoral referrals of survivors of sexual violence from the health sector*** in Kenya" in your sub-county.

Kindly give her the necessary assistance.

Signature Removed

MWACHIDUDU CHIMERA
FOR COUNTY COMMISSIONER
NAKURU COUNTY

5:5: Approval from the national department of reproductive health

MINISTRY OF HEALTH

Telegrams:"MINHEALTH",Nairobi
Telephone: Nairobi 2717077
E-mail: Pphs@health.go.ke
When replying please quote

AFYA HOUSE
CATHEDRAL ROAD
P.O. Box 30016-00100
NAIROBI.

31/10/2013

National Commission For Science, Technology and Innovation
8th - 9th Floor, Utalii House
off Uhuru Highway, Nairobi
P. O. Box 30623, 00100
Nairobi KENYA

To the Concerned,

RE: Ministry of Health/Division of Reproductive Health Support for Proposed PhD Study

I am writing in support of Ms Carolyne Ajema's research proposal on "***Utilisation of a multi-sectoral approach in strengthening cross-sectoral referrals of survivors of sexual violence from the health sector in Kenya.***"

I, (Ms Pamela Godia) as the Head of the Gender Program under the Ministry of Health's Division of Reproductive Health and Rukia Yassin(The Project Manager- SGB Networks Coordination Secretariat-Ministry of Health) are in support this project and would like to set out a number of reasons why her research will be of significant importance to the Ministry of Health.

Firstly, the management of cases of sexual violence requires close collaboration by the different sectors and stakeholders, yet there lacks evidence to show feasibility of implementing a multi sectoral referral pathway that can be adopted across sectors. This study will therefore play a key role in helping shed light on the current referral pathways and what is required in order to ensure that survivors get quality care across spectrum. Secondly, Kenya through the Ministry of Health has continually used research findings to inform systems strengthening and; policy formulation as well as to inform the development of interventions to assist these systems in improving services. Ms Ajema' study therefore has potential to not only inform local (Kenyan) practice, but also has

great potential to add to current debates on importance of a multi-sectoral approach to the prevention and response to sexual violence. Findings produced in this area will focus on how the health sector plays a key role in generating evidence that is heavily relied upon by the criminal justice system to ensure justice is served, hence need to understand how referral of evidence from the health sector can be improved upon. Ms Ajema will continually provide updates to the Sexual and Gender Based Violence (SGBV Coordination Secretariat of the Ministry of Health-Division of Reproductive Health).

I, Ms. Pamela Godia, as the Gender Program Manager at the Division of Reproductive Health together with Ms Rukia Yassin, the SGBV Secretariat Coordination Project Manager will continuously receive updates from Ms Ajema study to ensure that the study is implemented within the provisions of the National guidelines on the management of survivors of sexual violence

Should you require any additional information or clarity, please do not hesitate to contact me at godiapam@yahoo.com or ryassing.sgbvnetworks@outlook.com.

Yours faithfully

Signature Removed

Pamela Godia
Gender Program Manager
Ministry of Health
Division of Reproductive Health

Signature Removed

Rukia Yassin
Project Manager
Sexual Gender Based Violence Networks

5:6: Approval from the National Commission for Science, Technology and Innovation

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471, 2241349, 310571, 2219420
Fax: +254-20-318245, 318249
Email: secretary@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date: 9th January, 2013

NACOSTI/P/14/2502/451

Carolyne Ajema Agesa
University of Cape Town
SOUTH AFRICA

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Utilization of a multi-sectoral approach in strengthening cross-sectoral referrals of survivors of sexual violence from the health sector in Kenya,"*** I am pleased to inform you that you have been authorized to undertake research in **Kiambu and Nakuru Counties** for a period ending **28th February, 2014.**

You are advised to report to **the County Commissioners and the County Directors of Education, Kiambu and Nakuru Counties** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

Signature Removed

DR. M. K. RUGUTT, PhD, HSC.
DEPUTY COMMISSION SECRETARY
NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

Copy to:

The County Commissioner
The County Director of Education
Kiambu County

Copy to:

The County Commissioner
The County Director of Education
Kiambu County.

5.7: Approval from UCT HREC

HUMAN RESEARCH ETHICS COMMITTEE
15 NOV 2017
HEALTH SCIENCES FACULTY
UNIVERSITY OF CAPE TOWN

UNIVERSITY OF CAPE TOWN

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

FHS016: Annual Progress Report / New Ethics approval required

HREC office use only (FWA00001637; IRB00001938) **This serves as notification of annual approval, including any documentation described below.**			
☑ Approved	Annual progress report	Approved until/next renewal date	30 NOV 2018
☐ Not approved approval	See attached comments		
Signature Chairperson of the HREC	Signature Removed	Date signed	15/11/2017

Comments to PI from the HREC
Thank you for the various clarifications

Principal Investigator to complete the following:

1. Protocol information

Date form submitted	13 November 2017		
HREC REF Number	HREF 594/2010	Ethics Approval was granted until 15.01.2012	PhD research - approval
			Requested from August 2012
			Until end 2018
Protocol title	Utilisation of a multi-sectoral approach in strengthening cross sectoral referrals of survivors of sexual violence from the health sector in Kenya		
Protocol number (if applicable)			
Are there any sub-studies linked to this study?	☐ Yes ☐ ✓No		
If yes, could you please provide the HREC Ref's for all sub-studies? **Note:** A separate FHS016 must be submitted for each sub-study.			
Principal Investigator	Carolyne Ajema-Agesa		
Department / Office Internal Mail Address	P.O.Box 19835-00202, Nairobi,Kenya		

Appendix 6: Data collection tools

In-Depth Interview Guide: health care workers, service providers from other sectors, and survivors (guardians).

Tool 1: Interview guide for survivors (guardians):

1. What is the first point of reporting after the violation and the reasons for presenting there first? Any other points reported to?
2. How did they know where to go for help after the sexual violation (probe re: for issue reporting to police, health facility, children's department etc.); if they didn't go anywhere else, reasons for this.
3. What services did you receive at each of the places mentioned above? (Probe: Was this what they anticipated they would receive in terms of services?)
4. Were you referred to another sector for additional services? (Probe: What types of referrals were made, for what purposes and who initiated these referrals – the providers or survivors?).
5. How was the referral done? (Probe: procedures or directions given to survivor).
6. Kindly describe your experiences in accessing services provided by the different sectors (Probe based on the sectors they visited for care or support; challenges faced in moving across different sectors).
7. Did you uptake the referrals? (If not, Reasons why they did not access these services).
8. Do you have any challenges and needs that were not attended to?
9. In your opinion, what can be done to improve how the different sectors provide PRC services?

Tool 2: Interview guide for health care workers:

1. How many survivors of sexual violence received post rape care services over the last six months?
2. What services do you provide to survivors of sexual violence in this facility (institution)?
3. Who are most of the clients you see? (Probe: for age, social demographics.)
4. What are some of the reasons why survivors choose to report their complaints to the health facility first? (Probe: Type of services they received?)
5. Are there instances where survivors are referred elsewhere for further care? (Probe: What type of referrals are made, for what and who in this facility initiates these referrals – the providers or survivors?
6. Please describe the method(s) and the processes that are used to refer the clients. (Probe use of any of the following? Verbal (tell them where to go); Issue standard referral form; Blank paper used to write referral information; Telephone referral; Escort client).
7. If standard client referral forms are mentioned in question number six, (Probe: who provides these forms? How is the supply of Client Referral Forms monitored? How does the provider at the receiving organization know that a patient has been referred to them? How does your organization/institution know that a client completed the referral?
8. Is there a system to follow up with a client upon a referral? (IF SO, please explain how).
9. Referral tracking mechanisms in place within and outside the health facility (Probe: Is there a formal agreement between referring and receiving institutions? IF SO, please describe agreement in terms of services covered. *Request for a copy of the agreement)*

10. Are there any existing partnerships between healthcare providers and the other sectors involved in the provision of PRC services if yes, please describe (Probe: the education sector, the legal sector, and/or law enforcement?
11. Are there any existing referral networks between different providers? How do they function and who is responsible for this coordination? (probe: Procedures used in referring survivors for other medico-legal services; Procedures in place for linkage with other sectors (referral points).
12. Probe: issues and challenges in dealing with survivors of rape: in terms of the issues they present with; the referral procedures; the collaboration between sectors and any other issues.
13. How would you describe efforts to coordinate sexual violence-related services in this district?
14. Any suggestions for improvements in strengthening coordination amongst the different sectors?

Key informant guide for the other sectors and policymakers:

1. Would you please describe your current role and responsibilities with regards to survivors of sexual violence?
2. Do you get cases of sexual violence coming straight to you as the first point of reporting? (Explore their ideas on who tends to come straight to them; who do they tend to have referred to them?)
3. Do you receive any referrals of sexual violence cases from health facility – from whom and how? (Probe: Does the current referral system work?)

4. Kindly describe the mechanisms in place that facilitate cross-sectoral referral mechanisms in place (Probe: Documentation and referral procedures in place).
5. Is there a network or consortium in which coordination of post rape care service delivery in this region facilitated or discussed?
    a. IF SO, please describe. (Probe: which organizations participate in these meetings? How often do they meet? Who chairs this network?
    b. IF Not, what can be done to address this?
6. What are the existing linkages with other sectors in the region for cross-referral purposes (Probe: their experiences as regards the functioning of these linkages or the lack thereof)?
7. Gaps and challenges in dealing with survivors of sexual violence and in the current referral system, the extent and quality of collaboration and linkages
8. In addition to the formal support structures for survivors of sexual violence, are there people or places that also provide support to people who have experienced sexual violence (Probe: places or people who offer informal support).
9. How can coordination and linkages between the formal and informal support systems in this region be achieved (Probe: What ought to be put in place to facilitate ease of access of services across the different sectors by survivors).
10. Do you have any other stakeholders in this region that we could reach out to for this exercise?

Record inventory Tool

The following information was obtained from the institutional records (where available).

Client Referral Form	• Client characteristics: Sex and age (characteristics will vary by how data are to be disaggregated) • Name of referring organization • Date of referral initiation • Type of service referred to (the reason for referral) • Name of receiving facility • Date client is seen at receiving service • Description of services rendered at receiving facility • Date seen at referring service for counter-referral
Referring and receiving service registers	• Client ID • Client characteristics: Sex and age (characteristics will vary by how data intend to be disaggregated) • Date of referral initiation • Type of service referred to (the reason for referral) • Date client receives the service • Description of services rendered at receiving facility • Date client seen back at initiating facility for counter-referral (counter-referral received)

Receiving service:	• Client ID • Client characteristics: Sex and age (characteristics will vary by how data are to be disaggregated) • Date of referral initiation • Type of service referred to (the reason for referral) • Date client seen at receiving service • Description of services rendered at receiving facility • Date client seen back at initiating facility for counter-referral

REFERENCES

Abeid, M., Muganyizi, P., Olsson, P., Darj, E. & Axemo, P. 2014. Community perceptions of rape and child sexual abuse: a qualitative study in rural Tanzania. *BMC International Health and Human Rights,* 14**,** 23.

Abeya, S. G., Afework, M. F. & Yalew, A. W. 2012. Intimate partner violence against women in west Ethiopia: a qualitative study on attitudes, woman's response, and suggested measures as perceived by community members. *Reproductive Health,* 9**,** 14.

Abrahams, N. & Gevers, A. 2017. A rapid appraisal of the status of mental health support in post-rape care services in the Western Cape. *South African Journal of Psychiatry,* 23.

Abramsky, T., Watts, C. H., Garcia-Moreno, C., Devries, K., Kiss, L., Ellsberg, M., Jansen, H. A. & Heise, L. 2011. What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women's health and domestic violence. *BMC Public Health,* 11**,** 109.

Abuelgasim, K. 2018. "Who do I turn to?" The experiences of Sudanese women and Eritrean refugee women when trying to access healthcare services in Sudan after being subject to gender-based violence.

Adatho, M. 2011. Combining quantitative and qualitative methods for program monitoring and evaluation: Why are mixed method designs best? World Bank.

Ahrens, C. E., Campbell, R., Ternier-Thames, N. K., Wasco, S. M. & Sefl, T. 2007. Deciding whom to tell: Expectations and outcomes of rape survivors' first disclosures. *Psychology of Women Quarterly,* 31**,** 38-49.

Ajema, C., Kilonzo, N. & Buluma, B. 2008. Policy and Practical Implications in Delivery of Medico-Legal Services to Survivors of Sexual Violence in Kenya. Liverpool VCT, Care and Treatment: Policy Brief No. 2, August 2008.

Ajema, C., Mukoma, W., Kilonzo, N., Bwire, B. & Otwombe, K. 2011a. Challenges experienced by service providers in the delivery of medico-legal services to survivors of sexual violence in Kenya. *Journal of Forensic and Legal Medicine,* 18**,** 162-166.

Ajema, C., Mukoma, W., Kilonzo, N., Bwire, B. & Otwombe, K. 2011b. Challenges experienced by service providers in the delivery of medico-legal services to survivors of sexual violence in Kenya. *J Forensic Leg Med,* 18**,** 162-6.

Ajema, C., Ngunjiri, A., Ouko, J., Karuga, R. & Digolo, L. 2015. Health facility responsiveness to the needs of child survivors of sexual violence: A case study of Nyeri and Nakuru Counties, Kenya: LVCT Health

Ajzen, I. 1991. The theory of planned behaviour. *Organizational Behaviour and Human Decision Processes,* 50**,** 179-211.

Akmatov, M. K. 2010. Child abuse in 28 developing and transitional countries—results from the Multiple Indicator Cluster Surveys. *International Journal of Epidemiology,* 40**,** 219-227.

Alempijevic, D., Savic, S., Pavlekic, S. & Jecmenica, D. 2007. Severity of injuries among sexual assault victims. *Journal of Forensic and Legal Medicine,* 14**,** 266-269.

Alio, A. P., Nana, P. N. & Salihu, H. M. 2009. Spousal violence and potentially preventable single and recurrent spontaneous fetal loss in an African setting: cross-sectional study. *The Lancet,* 373**,** 318-324.

Andersen, R. & Newman, J. F. 1973. Societal and individual determinants of medical care utilization in the United States. *The Milbank Memorial Fund Quarterly. Health and Society***,** 95-124.

Andersen, R. M. 1995. Revisiting the behavioral model and access to medical care: does it matter? *Journal of Health and Social Behavior***,** 1-10.

Ansara, D. L. & Hindin, M. J. 2010. Formal and informal help-seeking associated with women's and men's experiences of intimate partner violence in Canada. *Social Science & Medicine,* 70**,** 1011-1018.

Ansara, D. L. & Hindin, M. J. 2011. Psychosocial consequences of intimate partner violence for women and men in Canada. *Journal of Interpersonal Violence,* 26**,** 1628-1645.

Antai, D. 2011. Traumatic physical health consequences of intimate partner violence against women: what is the role of community-level factors? *BMC Womens Health,* 11**,** 56.

Aronson, J. 1995. A pragmatic view of thematic analysis. *The qualitative report,* 2**,** 1-3.

Ashe, S., Duvvury, N., Raghavendra, S., Scriver, S. & O'donovan, D. 2016. Costs of violence against women: an examination of the evidence. *What Works to Prevention Violence: Economic and Social Cost of Violence against Women and Girls*.

Avdibegović, E. & Sinanović, O. 2006. Consequences of domestic violence on women's mental health in Bosnia and Herzegovina. *Croatian Medical Journal,* 47**,** 730-741.

Basile, K. C. 2015. A comprehensive approach to sexual violence prevention. *The New England Journal of Medicine,* 372**,** 2350.

Basile, K. C., Smith, S. G., Liu, Y., Kresnow, M.-J., Fasula, A. M., Gilbert, L. & Chen, J. 2018. Rape-related pregnancy and association with reproductive coercion in the US. *American Journal of Preventive Medicine,* 55**,** 770-776.

Bebbington, P., Jonas, S., Kuipers, E., King, M., Cooper, C., Brugha, T., Meltzer, H., Mcmanus, S. & Jenkins, R. 2011. Childhood sexual abuse and psychosis: data from a cross-sectional national psychiatric survey in England. *The British Journal of Psychiatry,* 199**,** 29-37.

Bell, M. E. & Goodman, L. A. 2001. Supporting battered women involved with the court system: An evaluation of a law school-based advocacy intervention. *Violence Against Women,* 7**,** 1377-1404.

Bonomi, A. E., Anderson, M. L., Rivara, F. P. & Thompson, R. S. 2009. Health care utilization and costs associated with physical and nonphysical-only intimate partner violence. *Health Services Research,* 44**,** 1052-1067.

Bott, S., Guedes, A., Claramunt, M. C. & Guezmes, A. 2004. Improving the health sector response to gender-based violence: a resource manual for health care professionals in developing countries.

Boyatzis, R. E. 1998. *Transforming qualitative information: Thematic analysis and code development*, SAGE.

Bouffard, L. and Goodson, A., 2017. Sexual coercion, sexual aggression, or sexual assault: How measurement impacts our understanding of sexual violence. *Journal of Aggression, Conflict and Peace Research*.

Braun, K. 2014. Legal Representation for Sexual Assault Victims—Possibilities for Law Reform? *Current Issues in Criminal Justice,* 25**,** 819-837.

Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative research in psychology,* 3**,** pp 16-22.

Brewer, J. & Hunter, A. 1989. *Multimethod research: A synthesis of styles*, Sage Publications, Inc.

Brown, D. W., Riley, L., Butchart, A., Meddings, D. R., Kann, L. & Harvey, A. P. 2009. Exposure to physical and sexual violence and adverse health behaviours in African children: results from the Global School-based Student Health Survey. *Bulletin of the World Health Organization,* 87**,** 447-455.

Bruyn, M. D. 2003. Violence, pregnancy and abortion. Issues of women's rights and public health, 2nd edition. Chapel Hill, NC, Ipas.

Buard, V., Van Den Bergh, R., Tayler-Smith, K., Godia, P., Sobry, A., Kosgei, R., Szumilin, E., Harries, A. & Pujades-Rodriguez, M. 2013. Characteristics, medical management and outcomes of survivors of sexual gender-based violence, Nairobi, Kenya. *Public health action,* 3**,** 109.

Buckingham, E. T. & Daniolos, P. 2013. Longitudinal outcomes for victims of child abuse. *Current psychiatry reports,* 15**,** 342.

Burgess, A. W. & Holmstrom, L. L. 1974. Crisis and counseling requests of rape victims. *Nursing Research*.

Campbell, J. C. 2002. Health consequences of intimate partner violence. *Lancet,* 359**,** 1331-6.

Campbell, R., Dworkin, E. & Cabral, G. 2009. An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse,* 10**,** 225-246.

Carretta, C. M., Burgess, A. W. & Demarco, R. 2015. To tell or not to tell. *Violence against women,* 21**,** 1145-1165.

Casey, S. E., Gallagher, M. C., Makanda, B. R., Meyers, J. L., Vinas, M. C. & Austin, J. 2011. Care-seeking behavior by survivors of sexual assault in the Democratic Republic of the Congo. *American journal of public health,* 101**,** 1054-1055.

Chandra, P. S., Satyanarayana, V. A. & Carey, M. P. 2009. Women reporting intimate partner violence in India: associations with PTSD and depressive symptoms. *Archives of women's mental health,* 12**,** 203.

Charillus, P. A. 2017. *An Assessment of the Implementation of Sexual Gender-Based Violence Policy in Winam Division, Kisumu County, Kenya.* Kenyatta University.

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., Elamin, M. B., Seime, R. J., Shinozaki, G. & Prokop, L. J. Sexual abuse and lifetime diagnosis of psychiatric disorders: systematic review and meta-analysis. Mayo clinic proceedings, 2010. Elsevier, 618-629.

Chingumbe, K. 2018. Exploring Coordination in a Multi-agency Partnership approach to Prevention of Gender-based violence in Zambia; Lessons from the Agencies' perception of the One-Stop center model of providing Coordinated psycho-social and medical support to the victims.

Chivers-Wilson, K. A. 2006. Sexual assault and posttraumatic stress disorder: A review of the biological, psychological and sociological factors and treatments. *McGill Journal of Medicine: MJM,* 9**,** 111.

Cohn, A. M., Zinzow, H. M., Resnick, H. S. & Kilpatrick, D. G. 2013. Correlates of reasons for not reporting rape to police: Results from a national telephone household probability sample of women with forcible or drug-or-alcohol facilitated/incapacitated rape. *Journal of Interpersonal Violence,* 28**,** 455-473.

Collumbien, M., Busza, J., Cleland, J. & Campbell, O. 2012. Social science methods for research on sexual and reproductive health. *Geneva: World Health Organization*.

Colombini, M., 2009, March. Background paper. In WHO Expert meeting on Health Sector Responses to IPV and SV (pp. 10-12).

Colombini, M., Mayhew, S. & Watts, C. 2008a. Health-sector responses to intimate partner violence in low-and middle-income settings: a review of current models, challenges and opportunities. *Bulletin of the World Health Organization,* 86**,** pp.635-642.

Colombini, M., Mayhew, S. & Watts, C. 2008b. Health-sector responses to intimate partner violence in low-and middle-income settings: a review of current models, challenges and opportunities. *Bulletin of the World Health Organization,* 86**,** 635-642.

Colombini, M., Mayhew, S. H., Ali, S. H., Shuib, R. & Watts, C. 2012. An integrated health sector response to violence against women in Malaysia: lessons for supporting scale up. *BMC Public Health,* 12**,** 548.

Cornally, N. & Mccarthy, G. 2011. Help-seeking behaviour: A concept analysis. *International journal of nursing practice,* 17**,** 280-288.

Cory, J., Ruebsaat, G., Hankivsky, O. & Dechief, L. 2003. Reasonable doubt: the use of health records in legal cases of violence against women in relationships. *BC Women's Hospital and Health Centre*.

Cousins, S. 2019. Isange One Stop Centre: sanctuary from violence in Rwanda. *The Lancet HIV,* 6**,** e12.

Creswell, J. W. & Creswell, J. D. 2017. *Research design: Qualitative, quantitative, and mixed methods approaches*, Sage publications.

Crichton, J., Nyamu-Musembi, C. & Ngugi, A. 2008. Painful tradeoffs: Intimate-partner violence and sexual and reproductive health rights in Kenya.

Cruz, G. V., Domingos, L. & Sabune, A. 2014. The characteristics of the violence against women in Mozambique. *Health,* 6**,** 1589.

Chynoweth, S.K., Buscher, D., Martin, S. and Zwi, A.B., 2020. A social-ecological approach to understanding service utilization barriers among male survivors of sexual violence in three refugee settings: a qualitative exploratory study. *Conflict and Health*, *14*(1), pp.1-13.

Dahlberg, L. L. & Mercy, J. A. 2009. The history of violence as a public health issue.

Daru, P., Osagie, E., Pam, I., Mutihir, J., Silas, O. & Ekwempu, C. 2011. Analysis of cases of rape as seen at the Jos University Teaching Hospital, Jos, north-central Nigeria. *Nigerian Journal of Clinical Practice,* 14.

Dartnall, E. and Jewkes, R., 2013. Sexual violence against women: the scope of the problem. *Best practice & research Clinical obstetrics & gynaecology*, *27*(1), pp.3-13.

Deb, S. & Walsh, K. 2012. Impact of physical, psychological, and sexual violence on social adjustment of school children in India. *School Psychology International,* 33**,** 391-415.

Decker, M. R., Latimore, A. D., Yasutake, S., Haviland, M., Ahmed, S., Blum, R. W., Sonenstein, F. & Astone, N. M. 2015. Gender-based violence against adolescent and young adult women in low-and middle-income countries. *Journal of Adolescent Health,* 56**,** 188-196.

Decker, M. R., Wilcox, H. C., Holliday, C. N. & Webster, D. W. 2018. An integrated public health approach to interpersonal violence and suicide prevention and response. *Public Health Reports,* 133**,** 65S-79S.

Degue, S. 2014. Preventing Sexual Violence on College Campuses: Lessons from Research and Practice.

DeGue, S. and DiLillo, D., 2005. "You would if you loved me": Toward an improved conceptual and etiological understanding of nonphysical male sexual coercion. *Aggression and Violent Behavior*, *10*(4), pp.513-532.

Devries, K., Watts, C., Yoshihama, M., Kiss, L., Schraiber, L. B., Deyessa, N., Heise, L., Durand, J., Mbwambo, J. & Jansen, H. 2011. Violence against women is strongly associated with suicide attempts: evidence from the WHO multi-country study on women's health and domestic violence against women. *Social science & medicine,* 73**,** 79-86.

Devries, K. M., Mak, J. Y., Garcia-Moreno, C., Petzold, M., Child, J. C., Falder, G., Lim, S., Bacchus, L. J., Engell, R. E. & Rosenfeld, L. 2013. The global prevalence of intimate partner violence against women. *Science,* 340**,** 1527-1528.

Dillon, G., Hussain, R., Loxton, D. & Rahman, S. 2013. Mental and physical health and intimate partner violence against women: A review of the literature. *International Journal of Family Medicine,* 2013.

Dinwiddie, S., Heath, A. C., Dunne, M. P., Bucholz, K. K., Madden, P. A., Slutske, W. S., Bierut, L. J., Statham, D. B. & Martin, N. G. 2000. Early sexual abuse and lifetime psychopathology: a co-twin–control study. *Psychological Medicine,* 30**,** 41-52.

Dossa, N. I., Zunzunegui, M. V., Hatem, M. & Fraser, W. 2014. Fistula and other adverse reproductive health outcomes among women victims of conflict-related sexual violence: A population-based cross-sectional study. *Birth,* 41**,** 5-13.

Draper, A. K. 2004. The principles and application of qualitative research. *Proceedings of the nutrition society,* 63**,** 641-646.

Du Mont, J., White, D., Organization., W. H. & Initiative, S. V. R. 2007. The uses and impacts of medico-legal evidence in sexual assault cases: A global review.

Dude, A. M. 2011. Spousal intimate partner violence is associated with HIV and other STIs among married Rwandan women. *AIDS and Behavior,* 15**,** 142-152.

Duncan, J. & Western, D. 2011. *Addressing'the Ultimate Insult': Responding to Women Experiencing Intimate Partner Sexual Violence*, Citeseer.

Duvvury, N., Carney, P. & Nguyen, H. M. 2012. *Estimating the costs of domestic violence against women in Viet Nam*, UN Women Viet Nam Country Office.

Dworkin, E. R., Menon, S. V., Bystrynski, J. & Allen, N. E. 2017. Sexual assault victimization and psychopathology: A review and meta-analysis. *Clinical Psychology Review,* 56**,** 65-81.

Ellery, F., Kassam, N. & Bazan, C. 2010. Prevention Pays: the economic benefits of ending violence in schools.: Plan international: uk.

Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H. & Garcia-Moreno, C. 2008. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *The Lancet,* 371**,** 1165-1172.

Eshelman, L. & Levendosky, A. A. 2012. Dating violence: Mental health consequences based on type of abuse. *Violence and Victims,* 27**,** 215-228.

Fanslow, J. L. & Robinson, E. M. 2010. Help-seeking behaviors and reasons for help seeking reported by a representative sample of women victims of intimate partner violence in New Zealand. *Journal of Interpersonal Violence,* 25**,** 929-951.

Fearon, J. & Hoeffler, A. 2014. Benefits and costs of the conflict and violence targets for the post-2015 development agenda. *Conflict and violence assessment paper, Copenhagen Consensus Center*.

Fenton, R. A., Mott, H. L., Mccartan, K. & Rumney, P. 2016. A review of evidence for bystander intervention to prevent sexual and domestic violence in universities.

Freccero, J., Harris, L., Carnay, M. & Taylor, C. 2011. Responding to sexual violence: Community approaches. *Sexual Violence & Accountability Project*.

García-Moreno, C., Hegarty, K., D'oliveira, A. F. L., Koziol-Mclain, J., Colombini, M. & Feder, G. 2015. The health-systems response to violence against women. *The Lancet,* 385**,** 1567-1579.-

Garcia-Moreno, C., Jansen, H. A., Ellsberg, M., Heise, L. & Watts, C. H. 2006. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *The Lancet,* 368**,** 1260-1269.

Garcia-Moreno, C. & Watts, C. 2011. Bulletin de l'Organisation mondiale de la Santé. *Bulletin de l'Organisation mondiale de la Santé,* 89**,** 2-2.

Gatuguta, A. 2018. *Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors: A systematic review and case study in Kenya.* London School of Hygiene & Tropical Medicine.

Gatuguta, A., Merrill, K. G., Colombini, M., Soremekun, S., Seeley, J., Mwanzo, I. & Devries, K. 2018. Missed treatment opportunities and barriers to comprehensive treatment for sexual violence survivors in Kenya: a mixed methods study. *BMC Public Health,* 18**,** 769.

Gender Based Violence Interagency Taskforce 2006. National Plan of Action for the Prevention and Management of Gender Based Violence in Liberia. (GBV-POA). *Available at: temp. supportliberia. com/assets/34/National_GBV_Plan_of_Action_2006. pdf*.

Gennari, F., Harris-Sapp, T., Simmons, K. & Messner, L. 2016. Lessons from the Gender-Based Violence Initiative in Mozambique.

Gevers, A., Abrahams, N., Andrews, G. & Toledo, C. 2015. Capacity assessment of mental health services for rape victims in acute health [care settings: A rapid appraisal of services in the Western Cape Province. Cape Town, South Africa: South African Medical Research Council.

Gihwala, R. T. 2016. *Out-of-hospital assessment and management of rape survivors by pre-hospital emergency care providers in the Western Cape.* University of Cape Town.

Glesne, C. 2006. Becoming qualitative researchers: An introduction Boston. Pearson Education.

Golafshani, N. 2003. Understanding reliability and validity in qualitative research. *The qualitative report,* 8**,** 597-606.

Goodman, L. A., Salyers, M. P., Mueser, K. T., Rosenberg, S. D., Swartz, M., Essock, S. M., Osher, F. C., Butterfield, M. I. & Swanson, J. 2001. Recent victimization in women and men with severe mental illness: prevalence and correlates. *Journal of traumatic stress,* 14**,** 615-632.

Goodman, L. A., Smyth, K. F., Borges, A. M. & Singer, R. 2009. When crises collide: How intimate partner violence and poverty intersect to shape women's mental health and coping? *Trauma, Violence, & Abuse,* 10**,** 306-329.

Government of Kenya 2006a. Witness Protection Act, act no 16 of 2006. Government of Kenya.

Government of Kenya. 2012. Sexual Offences Act medical treatment regulations. Government of Kenya.

Government of Kenya. 2006b. The Sexual Offences Act, No. 3 of 2006. Government of Kenya.

Government of Kenya,2014. National policy for prevention and response to gender-based violence. Government of Kenya

Government of Malawi 2014. National plan of action to combat gender-based violence in Malawi (2014-2020).

Government of the Republic of Zambia 2010. Guidelines for the Multidisciplinary Management of Sexual and Gender-Based Violence in Zambia.

Greathouse, S.M., Saunders, J.M., Matthews, M., Keller, K.M. and Miller, L.L., 2015. *A review of the literature on sexual assault perpetrator characteristics and behaviors*. Santa Monica, CA: Rand Corporation.

Guba, E. G. 1981. Criteria for assessing the trustworthiness of naturalistic inquiries. *Ectj,* 29**,** 75.

Hall, M., Chappell, L. C., Parnell, B. L., Seed, P. T. & Bewley, S. 2014. Associations between intimate partner violence and termination of pregnancy: a systematic review and meta-analysis. *PLoS medicine,* 11**,** e1001581.

Hälsa, V. O. 2014. 2014. A population survey on women's and men's vulnerability to violence and the connection to health.

Heale, R. & Twycross, A. 2015. Validity and reliability in quantitative studies. *Evidence-based nursing,* 18**,** 66-67.

Heath, N. M., Lynch, S. M., Fritch, A. M., Mcarthur, L. N. & Smith, S. L. 2011. Silent survivors: Rape myth acceptance in incarcerated women's narratives of disclosure and reporting of rape. *Psychology of Women Quarterly,* 35**,** 596-610.

Heise, L., Ellsberg, M. & Gottmoeller, M. 2002. A global overview of gender-based violence. *Int J Gynaecol Obstet,* 78 Suppl 1**,** S5-14.

Heise, L., Greene, M. E., Opper, N., Stavropoulou, M., Harper, C., Nascimento, M., Zewdie, D., Darmstadt, G. L., Greene, M. E. & Hawkes, S. 2019. Gender inequality and restrictive gender norms: framing the challenges to health. *The Lancet*.

Henttonen, M., Watts, C., Roberts, B., Kaducu, F. & Borchert, M. 2008. Health services for survivors of gender-based violence in northern Uganda: a qualitative study. *Reproductive Health Matters,* 16**,** 122-131.

Hillis, S., Mercy, J., Amobi, A. & Kress, H. 2016. Global prevalence of past-year violence against children: a systematic review and minimum estimates. *Pediatrics,* 137**,** e20154079.

Holton, G., Joyner, K. & Mash, R. 2018. Sexual assault survivors' perspectives on clinical follow-up in the Eden District, South Africa: A qualitative study. *African Journal of Primary Health Care & Family Medicine,* 10**,** 1-7.

Hoyt, C. A. 1999. Evidence recognition and collection in the clinical setting. *Critical care nursing quarterly,* 22**,** 19-26.

Human Rights Watch 2017. They Were Men in Uniform" Sexual Violence against Women and Girls in Kenya's 2017 Elections

Ikamari, L., Izugbara, C. & Ochako, R. 2013. Prevalence and determinants of unintended pregnancy among women in Nairobi, Kenya. *BMC Pregnancy and Childbirth,* 13**,** 69.

Isser, D., Lubkemann, S. C. & N'tow, S. 2009. Looking for Justice: Liberian Experiences with and Perceptions of Local Justice Options (Washington, DC: United States Institute of Peace).

Ivey, J. 2012. The value of qualitative research methods. *Pediatric Nursing,* 38**,** 319-320.

Jacques-Tiura, A. J., Tkatch, R., Abbey, A. & Wegner, R. 2010. Disclosure of sexual assault: Characteristics and implications for posttraumatic stress symptoms among African American and Caucasian survivors. *Journal of Trauma & Dissociation,* 11**,** 174-192.

Jaycox, L. H., Zoellner, L. & Foa, E. B. 2002. Cognitive–Behavior Therapy for PTSD in Rape Survivors. *Psychotherapy in Practice,* 58**,** 891–906

Jayne, M. & Valentine, G. 2016. Alcohol-related violence and disorder: New critical perspectives. *Progress in Human Geography,* 40**,** 67-87.

Jewkes, R. 2002. Intimate partner violence: causes and prevention. *The Lancet,* 359**,** pp.1423-1429.

Jewkes, R. 2014. What works to prevent violence against women and girls?

Jewkes, R. 2016. What works to prevent violence against women and girls? Evidence review of the effectiveness of response mechanisms in preventing violence against women and girls. Government of UK. Available from: https://www. gov. uk/government/uploads/system/uploads/attachment_data/file/337622/evidence-review-response-mechanisms-H. pdf. Accessed.

Jina, R. & Thomas, L. S. 2013. Health consequences of sexual violence against women. *Best Practice & Research Clinical Obstetrics & Gynaecology,* 27**,** 15-26.

Jones, A. S., Dienemann, J., Schollenberger, J., Kub, J., O'campo, P., Gielen, A. C. & Campbell, J. C. 2006. Long-term costs of intimate partner violence in a sample of female HMO enrollees. *Women's Health Issues,* 16**,** 252-261.

Josse, E. 2010. 'They came with two guns': the consequences of sexual violence for the mental health of women in armed conflicts. *International Review of the Red Cross,* 92**,** 177-195.

Juvrud, J. & Rennels, J. L. 2017. “I don’t need help”: Gender differences in how gender stereotypes predict help-seeking. *Sex Roles,* 76**,** 27-39.

Kabiru, C. W. & Orpinas, P. 2009. Factors associated with sexual activity among high-school students in Nairobi, Kenya. *Journal of Adolescence,* 32**,** 1023-1039.

Kalra, G. & Bhugra, D. 2013. Sexual violence against women: Understanding cross-cultural intersections. *Indian journal of psychiatry,* 55**,** 244.

Kamimura, A., Parekh, A. & Olson, L. M. 2013. Health indicators, social support, and intimate partner violence among women utilizing services at a community organization. *Women's Health Issues,* 23**,** e179-e185.

Kaneda, T. & Smith, R. 2015. Intimate Partner Violence and Unmet Need for Family Planning.: PRB.

KDHS 2014. Kenya Demographic Health Survey.

Keesbury, J. & Askew, I. 2010. Comprehensive responses to gender-based violence in low-resource settings: Lessons learned from implementation. Population Council. Lusaka, Zambia.

Keesbury, J., Onyango-Ouma, W., Undie, C.-C., Maternowska, C., Mugisha, F., Kageha, E. & Askew, I. 2012. A review and evaluation of multi-sectoral response services ('one-stop centers') for gender-based violence in Kenya and Zambia.

Kelly, J., Betancourt, T. S., Mukwege, D., Lipton, R. & Vanrooyen, M. J. 2011. Experiences of female survivors of sexual violence in eastern Democratic Republic of the Congo: a mixed-methods study. *Conflict and Health,* 5**,** 25.

Kelly, J., Kabanga, J., Cragin, W., Alcayna-Stevens, L., Haider, S. & Vanrooyen, M. J. 2012. ‘If your husband doesn't humiliate you, other people won't’: gendered attitudes towards sexual violence in eastern Democratic Republic of Congo. Global public health, 7, 285-298.

Kenya National Bureau of Statistics 2016. Economic Survey

Kilonzo, N. 2003. Post Rape Services in Kenya: A Situation Analysis. Nairobi, Kenya: Liverpool VCT and care Kenya.

Kilonzo, N. 2007. *The practical and policy requirements for implementing post rape care services in resource limited settings.* University of Liverpool.

Kilonzo, N., Dartnall, E. & Obbayi, M. 2013. Briefing paper: Policy and practice requirements for bringing to scale sexual violence services in low resource settings. Liverpool VCT Care and Treatment/Sexual Violence Research Initiative. Nairobi.

Kilonzo, N., Ndung'u, N., Nthamburi, N., Ajema, C., Taegtmeyer, M., Theobald, S. & Tolhurst, R. 2009a. Sexual violence legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages. *Reprod Health Matters,* 17**,** 10-19.

Kilonzo, N., Ndung'u, N., Nthamburi, N., Ajema, C., Taegtmeyer, M., Theobald, S. & Tolhurst, R. 2009b. Sexual violence legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages. *Reproductive health Matters,* 17**,** 10-19.

Kilonzo, N., Taegtmeyer, M., Molyneux, C., Kibaru, J., Kimonji, V. & Theobald, S. 2008a. Engendering health sector responses to sexual violence and HIV in Kenya: results of a qualitative study. *AIDS Care,* 20**,** 188-90.

Kilonzo, N., Taegtmeyer, M., Molyneux, C., Kibaru, J., Kimonji, V. & Theobald, S. 2008b. Engendering health sector responses to sexual violence and HIV in Kenya: Results of a qualitative study. *AIDS care,* 20**,** 188-190.

Kilonzo, N., Theobald, S., Nyamato, E., Ajema, C., Muchela, H., Kibaru, J., Rogena, E. & Taegtmeyer, M. 2009c. Delivering post-rape care services: Kenya's experience in developing integrated services. *Bulletin of the World Health Organization,* 87**,** 555-559.

Kilonzo, N., Theobald, S. J., Nyamato, E., Ajema, C., Muchela, H., Kibaru, J., Rogena, E. & Taegtmeyer, M. 2009d. Delivering post-rape care services: Kenya's experience in developing integrated services. *Bulletin of the World Health Organization,* 87**,** 555-559.

Kiruki, M., Ajema, C., Kyongo, J., Owuor, K., Mbugua, C., Kotut, R. & Digolo, L. 2017. Enhancing Access to Comprehensive Post-Rape Care Services for Children in Kenya. Nairobi, Kenya: LVCT Health.

Kmett Danielson, C., Macdonald, A., Amstadter, A. B., Hanson, R., De Arellano, M. A., Saunders, B. E. & Kilpatrick, D. G. 2010. Risky behaviors and depression in conjunction with—or in the absence of—lifetime history of PTSD among sexually abused adolescents. *Child Maltreatment,* 15**,** 101-107.

KNBS 2010. Kenya 2009 population and housing census highlights.

Kohli, A., Makambo, M. T., Ramazani, P., Zahiga, I., Mbika, B., Safari, O., Bachunguye, R., Mirindi, J. & Glass, N. 2012. A Congolese community-based health program for survivors of sexual violence. *Conflict and health,* 6**,** 6.

Koo, K. H., Nguyen, H. V., Andrasik, M. P. & George, W. H. 2015. The cultural context of nondisclosure of alcohol-involved acquaintance rape among Asian American college women: A qualitative study. *The Journal of Sex Research,* 52**,** 55-68.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B. & Lozano, R. 2002. World Report on Violence and Health. World Health Organization, Geneva.

Kuria, M. W., Omondi, L., Olando, Y., Makenyengo, M. & Bukusi, D. 2013. Is sexual abuse a part of war? A 4-year retrospective study on cases of sexual abuse at the Kenyatta National Hospital, Kenya. *Journal of Public Health in Africa,* 4.

Laisser, R. M., Lugina, H. I., Lindmark, G., Nystrom, L. & Emmelin, M. 2009. Striving to make a difference: health care worker experiences with intimate partner violence clients in Tanzania. *Health care for women international,* 30**,** 64-78.

Laisser, R. M., Nyström, L., Lugina, H. I. & Emmelin, M. 2011. Community perceptions of intimate partner violence-a qualitative study from urban Tanzania. *BMC Women's Health,* 11**,** 13.

Leiner, A. S., Kearns, M. C., Jackson, J. L., Astin, M. C. & Rothbaum, B. O. 2012. Avoidant coping and treatment outcome in rape-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology,* 80**,** 317.

Leininger, M. M. 1985. Ethnography and ethnonursing: Models and modes of qualitative data analysis. *Qualitative research methods in nursing***,** 33-72.

LeMaire, K.L., Oswald, D.L. and Russell, B.L., 2016. Labeling sexual victimization experiences: the role of sexism, rape myth acceptance, and tolerance for sexual harassment. *Violence and Victims*, *31*(2), pp.332-346.

Levy, M., Messner, L., Duffy, M. & Casto, J. 2016. Strengthening linkages between clinical and social/community services for children and adolescents who have experienced sexual violence: A companion guide.

Liebling-Kalifani, H. & Baker, B. 2010. Justice and health Provision for survivors of sexual violence in Kitgum, Northern Uganda. *African Journal,* 1**,** 22.

Littel, K. 2001. *Sexual assault nurse examiner (SANE) programs: Improving the community response to sexual assault victims*, US Department of Justice, Office of Justice Programs, Office for Victims of Crime.

Longombe, A. O., Claude, K. M. & Ruminjo, J. 2008. Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: case studies. *Reproductive Health Matters,* 16**,** 132-141.

Maguire, W., Goodall, E. & Moore, T. 2009. Injury in adult female sexual assault complainants and related factors. *European Journal of Obstetrics & Gynecology and Reproductive Biology,* 142**,** 149-153.

Mannell, J., Seyed-Raeisy, I., Burgess, R. & Campbell, C. 2018. The implications of community responses to intimate partner violence in Rwanda. *PloS one,* 13**,** e0196584.

Martin, S. L., Young, S. K., Billings, D. L. & Bross, C. C. 2007. Health care-based interventions for women who have experienced sexual violence: A review of the literature. *Trauma, Violence, & Abuse,* 8**,** 3-18.

Maseno, L. & Kilonzo, S. M. 2011. Engendering development: Demystifying patriarchy and its effects on women in rural Kenya. *International Journal of Sociology and Anthropology,* 3**,** 45-55.

Mccleary-Sills, J., Namy, S., Nyoni, J., Rweyemamu, D., Salvatory, A., Steven, E. & ICRW, 2013. *Help-Seeking Pathways and Barriers for Survivors of Gender-based Violence in Tanzania. Results from a Study in Dar Es Salaam, Mbeya, and Iringa Regions*, International Center for Research on Women (McCleary-Sills et al., 2013).

Mccollister, K. E., French, M. T. & Fang, H. 2010. The cost of crime to society: New crime-specific estimates for policy and program evaluation. *Drug and alcohol dependence,* 108**,** 98-109.

Mcfarlane, J., Malecha, A., Watson, K., Gist, J., Batten, E., Hall, I. & Smith, S. 2005. Intimate partner sexual assault against women: frequency, health consequences, and treatment outcomes. *Obstetrics & Gynecology,* 105**,** 99-108.

Mcgregor, M. J., Le, G., Marion, S. A. & Wiebe, E. 1999. Examination for sexual assault: Is the documentation of physical injury associated with the laying of charges? A retrospective cohort study. *Cmaj,* 160**,** 1565-1569.

Mclean, I., Roberts, S. A., White, C. & Paul, S. 2011. Female genital injuries resulting from consensual and non-consensual vaginal intercourse. *Forensic science international,* 204**,** 27-33.

Mcmahon, P. M. 2000. The public health approach to the prevention of sexual violence. *Sexual Abuse: A Journal of Research and Treatment,* 12**,** 27-36.

Medie, P. A. 2013. Fighting gender-based violence: The women's movement and the enforcement of rape law in Liberia. *African Affairs,* 112**,** 377-397.

Meinck, F., Cluver, L., Loening-Voysey, H., Bray, R., Doubt, J., Casale, M. & Sherr, L. 2017. Disclosure of physical, emotional and sexual child abuse, help-seeking and access to abuse response services in two South African Provinces. *Psychology, health & medicine,* 22**,** 94-106.

Melek, M., Albrectsen, A.-B., Agduk, M., Bojorquez, N. & Cordoba, A. 2006. Programming to address violence against women: 10 case studies.

Merritt, D. F. 2008. Genital trauma in children and adolescents. *Clinical obstetrics and gynecology,* 51**,** 237-248.

Ministry of Health 2012. Guidelines for Provision of Comprehensive services for survivors of physical and sexual violence at health facilities in Malawi (One-Stop Centres). Revised Edition 2012. Lilongwe: Ministry of Health, 2012. 79 United Nations Population Fund Asia.

Ministry of Health 2016. National Guidelines on Management of Sexual Violence in Kenya. Ministry of Health Kenya.

Ministry of Labour and Social Protection of Kenya, Department of Children's Services. Violence against Children in Kenya: Findings from a National Survey, 2019. Nairobi, Kenya: 2019.

Mmbaga, E. J., Leyna, G. H., Mnyika, K. S., Hussain, A. & Klepp, K.-I. 2007. Education attainment and the risk of HIV-1 infections in rural Kilimanjaro Region of Tanzania, 1991–2005: a reversed association. *Sexually transmitted diseases,* 34**,** 947-953.

Ministry of Health (MoH) 2014. National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya.

Mondin, T.C., Cardoso, T.D.A., Jansen, K., Konradt, C.E., Zaltron, R.F., Behenck, M.D.O., Mattos, L.D.D. and Silva, R.A.D., 2016. Sexual violence, mood disorders and suicide risk: a population-based study. *Ciencia & saude coletiva*, *21*, pp.853-860.

Muganyizi, P. S., Hogan, N., Emmelin, M., Lindmark, G., Massawe, S., Nystrom, L. & Axemo, P. 2009. Social reactions to rape: experiences and perceptions of women rape survivors and their potential support providers in Dar es Salaam, Tanzania. *Violence and Victims,* 24**,** 607.

Muia, E., Ellertson, C., Clark, S., Lukhando, M., Elul, B., Olenja, J. & Westley, E. 2000. What do family planning clients and university students in Nairobi, Kenya, know and think about emergency contraception? *African Journal of Reproductive Health,* 4**,** 77-87.

Mulambia, Y., Miller, A. J., Macdonald, G. & Kennedy, N. 2018. Are one-stop centres an appropriate model to deliver services to sexually abused children in urban Malawi? *BMC Pediatrics,* 18**,** 145.

Munala, L., Welle, E., Hohenshell, E. & Okunna, N. 2018. "She Is NOT a Genuine Client": Exploring Health Practitioner's Mistrust of Rape Survivors in Nairobi, Kenya. *International quarterly of community health education,* 38**,** 217-224.

Muthoni, C. 2019. *Information Seeking Behaviour of Women in Kenya To Protect Themselves from Sexual Gender-Based Violence.* Masters, Åbo Akademi University.

National Crime Victim Law Institute 2005. Rights and remedies: Meeting the civil legal needs of sexual violence survivors The Center for Law & Public Policy on Sexual Violence.

NGEC 2016. Gender-based violence in Kenya: The economic burden on survivors.

Nguyen, K. H., Padilla, M., Villaveces, A., Patel, P., Atuchukwu, V., Onotu, D., Apondi, R., Aluzimbi, G., Chipimo, P. & Kancheya, N. 2019. Coerced and forced sexual initiation and its association with negative health outcomes among youth: results from the Nigeria, Uganda, and Zambia violence against children surveys. *Child Abuse & Neglect,* 96**,** 104074.

Njuki, R., Okal, J., Warren, C. E., Obare, F., Abuya, T., Kanya, L., Undie, C.-C., Bellows, B. & Askew, I. 2012. Exploring the effectiveness of the output-based aid voucher program to increase uptake of gender-based violence recovery services in Kenya: a qualitative evaluation. *BMC Public Health,* 12**,** 426.

NPS 2019. Annual crime report 2018, Kenya.

Odero, M., Hatcher, A. M., Bryant, C., Onono, M., Romito, P., Bukusi, E. A. & Turan, J. M. 2014. Responses to and resources for intimate partner violence: qualitative findings from women, men, and service providers in rural Kenya. *Journal of Interpersonal Violence,* 29**,** 783-805.

Odwe, G., Undie, C.-C. & Obare, F. 2018. Attitudes towards help-seeking for sexual and gender-based violence in humanitarian settings: the case of Rwamwanja refugee settlement scheme in Uganda. *BMC international health and human rights,* 18**,** 15.

Ofwona, L. L. 2015. *Barriers to Help-Seeking Faced by Women Survivors of Gender-Based Violence in Kesses Sub-County, Uasin Gishu County, North-Rift Kenya.* University of Nairobi.

Omanyondo, M., 2005. Sexual gender-based violence and health facility needs assessment. *World Health Organization*.

Onsrud, M., Sjøveian, S., Luhiriri, R. & Mukwege, D. 2008. Sexual violence-related fistulas in the Democratic Republic of Congo. *International Journal of Gynecology & Obstetrics,* 103**,** 265-269.

Oseni, T. I., Lawani, O. E. & Oyedeji, A. I. 2016. A case study of sexual abuse of a minor. *African journal of reproductive health,* 20**,** 109-113.

Overstreet, N.M. and Quinn, D.M., 2013. The intimate partner violence stigmatization model and barriers to help-seeking. *Basic and applied social psychology*, *35*(1), pp.109-122.

Palermo, T., Bleck, J. & Peterman, A. 2013. Tip of the iceberg: reporting and gender-based violence in developing countries. *American Journal of Epidemiology,* 179**,** 602-612.

Pallitto, C. C. & O'campo, P. 2004. The relationship between intimate partner violence and unintended pregnancy: analysis of a national sample from Colombia. *International Family Planning Perspectives***,** pp.165-173.

Patel, D. M. 2011. *Preventing violence against women and children: Workshop summary*, National Academies Press.

Pattavina, A., Morabito, M. & Williams, L. M. 2016. Examining connections between the police and prosecution in sexual assault case processing: Does the use of exceptional clearance facilitate a downstream orientation? *Victims & Offenders,* 11**,** 315-334.

Patton, M. Q. 1990. *Qualitative evaluation and research methods*, SAGE Publications, inc.

Peltzer, K., Pengpid, S., Mcfarlane, J. & Banyini, M. 2013. Mental health consequences of intimate partner violence in Vhembe district, South Africa. *Gen Hosp Psychiatry,* 35**,** 545-50.

Peterson, C., Florence, C. & Klevens, J. 2018. The economic burden of child maltreatment in the United States, 2015. *Child Abuse & Neglect,* 86**,** 178-183.

Phipps, A. & Smith, G. 2012. Violence against women students in the UK: Time to take action. *Gender and Education,* 24**,** 357-373.

Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburúa, E. & Martinez, M. 2006. The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide. *Journal of Women's Health,* 15**,** 599-611.

Pineles, S. L., Mostoufi, S. M., Ready, C. B., Street, A. E., Griffin, M. G. & Resick, P. A. 2011. Trauma reactivity, avoidant coping, and PTSD symptoms: A moderating relationship? *Journal of Abnormal Psychology,* 120**,** 240.

Plummer, C. A. & Njuguna, W. 2009. Cultural protective and risk factors: Professional perspectives about child sexual abuse in Kenya. *Child Abuse & Neglect,* 33**,** 524-532.

Pope, C. & Mays, N. 1995. Qualitative research: reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ,* 311**,** 42-45.

Raghavendra, S., Duvvury, N. & Ashe, S. 2017. The Macroeconomic Loss due to Violence Against Women: The Case of Vietnam. *Feminist Economics,* 23**,** 62-89.

Ramakuela, N. J., Lebese, T. R., Maputle, S. M. & Mulaudzi, L. 2016. Views of teenagers on termination of pregnancy at Muyexe high school in Mopani District, Limpopo Province, South Africa. *African Journal of Primary Health Care & Family Medicine,* 8.

Ranney, M. L., Rennert-May, E., Spitzer, R., Chitai, M. A., Mamlin, S. E. & Mabeya, H. 2011a. A novel ED-based sexual assault centre in western Kenya: description of patients and analysis of treatment patterns. *Emerg Med J,* 28(Ranney et al., 2011)**,** pp.927-931.

Ranney, M. L., Rennert-May, E., Spitzer, R., Chitai, M. A., Mamlin, S. E. & Mabeya, H., 2011b. A novel ED-based sexual assault centre in western Kenya: description of patients and analysis of treatment patterns. *Emerg Med J,* 28**,** 927-931.

Government of Kenya, *Act No. 3 of 2006, The Sexual Offences Act 2006* [Kenya], 21 July 2006, available at: https://www.refworld.org/docid/467942932.html [accessed 18 October 2020]

Rivara, F. P., Anderson, M. L., Fishman, P., Bonomi, A. E., Reid, R. J., Carrell, D. & Thompson, R. S. 2007. Healthcare utilization and costs for women with a history of intimate partner violence. *American Journal of Preventive Medicine,* 32**,** 89-96.

Robinson, A., Hudson, K. & Brookman, F. 2008. Multi-Agency Work on Sexual Violence: Challenges and Prospects Identified from the Implementation of a Sexual Assault Referral Centre (SARC). *The Howard Journal of Criminal Justice,* 47**,** 411-428.

Ryan, G. W. & Bernard, H. R. 2000. Data management and analysis methods.

Sabina, C. & Ho, L. Y. 2014. Campus and college victim responses to sexual assault and dating violence: Disclosure, service utilization, and service provision. *Trauma, Violence, & Abuse,* 15**,** 201-226.

Sable, M. R., Danis, F., Mauzy, D. L. & Gallagher, S. K. 2006. Barriers to reporting sexual assault for women and men: Perspectives of college students. *Journal of American College Health,* 55**,** 157-162.

Saidi, H., Awori, K. O. & Odula, P. 2008. Gender-associated violence at a women's hospital in Nairobi, Kenya. *East African medical journal,* 85**,** 347-354.

Salehi Fadardi, J. 2009. A comparative study of anxiety, stress, and depression in physically abused and non-abused Iranian wives. *Iranian Journal of Psychiatry and Behavioral Sciences,* 3.

Savolainen, R. 2016. Approaches to socio-cultural barriers to information seeking. *Library & Information Science Research,* 38**,** 52-59.

Schulz, P. 2018. The “ethical loneliness” of male sexual violence survivors in Northern Uganda: gendered reflections on silencing. *International Feminist Journal of Politics,* 20**,** 583-601.

Schwandt, T. A. 2007. Thematic analysis. *The SAGE dictionary of qualitative inquiry***,** 292.

Shako, K. & Kalsi, M. 2019a. Forensic observations and recommendations on sexual and gender-based violence in Kenya. *Forensic Science International: Synergy,* 1**,** 185-203.

Shako, K. & Kalsi, M. 2019b. Forensic observations and recommendations on the management of sexual and Gender Based Violence in Kenya. *Forensic Science International: Synergy*.

Shamu, S., Zarowsky, C., Roelens, K., Temmerman, M. & Abrahams, N. 2016. High-frequency intimate partner violence during pregnancy, postnatal depression and suicidal tendencies in Harare, Zimbabwe. *General hospital psychiatry,* 38**,** 109-114.

Shao, S., Wang, M., Jin, G., Zhao, Y., Lu, X. and Du, J., 2018. Analysis of health service utilization of migrants in Beijing using Anderson health service utilization model. *BMC Health Services Research*, *18*(1), p.462.

Sheridan, D. J. & Nash, K. R. 2007. Acute injury patterns of intimate partner violence victims. *Trauma, Violence, & Abuse,* 8**,** 281-289.

Silverman, J. G., Gupta, J., Decker, M. R., Kapur, N. & Raj, A. 2007. Intimate partner violence and unwanted pregnancy, miscarriage, induced abortion, and stillbirth among a national sample of Bangladeshi women. *BJOG: An International Journal of Obstetrics & Gynaecology,* 114**,** 1246-1252.

Sithole, Z., Gombe, N. T., Juru, T., Chonzi, P., Shambira, G., Nsubuga, P. & Tshimanga, M. 2018. Evaluation of sexual and gender-based violence program in Harare City, Zimbabwe, 2016: a descriptive cross-sectional study. *The Pan African Medical Journal,* 31.

Skosana, B. S. 2016. *Provider perceptions of the quality of post-rape care in Ekurhuleni District.*

Smith, J. R., Ho, L. S., Langston, A., Mankani, N., Shivshanker, A. & Perera, D. 2013. Clinical care for sexual assault survivor's multimedia training: a mixed-methods study of effect on healthcare providers' attitudes, knowledge, confidence, and practice in humanitarian settings. *Conflict and health,* 7**,** 14.

Speight, C. G., Klufio, A., Kilonzo, S. N., Mbugua, C., Kuria, E., Bunn, J. E. & Taegtmeyer, M. 2006. Piloting post-exposure prophylaxis in Kenya raises specific concerns for the management of childhood rape. *Transactions of the Royal Society of Tropical Medicine and Hygiene,* 100(Ranney et al., 2011)**,** pp. 14-18.

Spivak, H. R., Jenkins, E. L., Vanaudenhove, K., Lee, D., Kelly, M. & Iskander, J. 2014. CDC grand rounds: A public health approach to prevention of intimate partner violence. *MMWR. Morbidity and mortality weekly report,* 63**,** 38.

Stephenson, R., Jadhav, A., Winter, A. & Hindin, M. 2016. Domestic violence and abortion among rural women in four Indian states. *Violence against women,* 22**,** 1642-1658.

Stephenson, R., Koenig, M. A., Acharya, R. & Roy, T. K., 39(Stephenson et al., 2008), 2008. Domestic violence, contraceptive use, and unwanted pregnancy in rural India. *Studies in Family Planning,* 39**,** pp.177-186.

Stöckl, H., Filippi, V., Watts, C. & Mbwambo, J. K. 2012. Induced abortion, pregnancy loss and intimate partner violence in Tanzania: a population-based study. *BMC Pregnancy and Childbirth,* 12**,** 12.

Stoltenborgh, M., Van Ijzendoorn, M. H., Euser, E. M. & Bakermans-Kranenburg, M. J. 2011. A global perspective on child sexual abuse: meta-analysis of prevalence around the world. *Child Maltreatment,* 16**,** 79-101.

Sullivan, C. M. 2012. Domestic violence shelter services: A review of the empirical evidence. *Harrisburg, PA: National Resource Center on Domestic Violence. Retrieved May* 9**,** 2016.

Swart, L.-A., Gilchrist, A., Butchart, A., Seedat, M. & Martin, L. 2000. Rape surveillance through district surgeon offices in Johannesburg, 1996–1998: findings, evaluation and prevention implications. *South African Journal of Psychology,* 30**,** 1-10.

Swedo, E. A., Sumner, S. A., Hillis, S. D., Aluzimbi, G., Apondi, R., Atuchukwu, V. O., Auld, A. F., Chipimo, P. J., Conkling, M. & Egbe, O. E. 2019. Prevalence of Violence Victimization and Perpetration Among Persons Aged 13–24 Years—Four Sub-Saharan African Countries, 2013–2015. *Morbidity and Mortality Weekly Report,* 68**,** 350.

Syombua, W. 2014. *Factors inhibiting the realization of legal justice for sexual violence survivors in kibera slums.* University of Nairobi.

Tappis, H., Freeman, J., Glass, N. & Doocy, S. 2016. Effectiveness of interventions, programs and strategies for gender-based violence prevention in refugee populations: an integrative review. *PLoS currents,* 8.

Tasca, M., Rodriguez, N., Spohn, C. & Koss, M. P. 2013. Police decision making in sexual assault cases: Predictors of suspect identification and arrest. *Journal of Interpersonal Violence,* 28**,** 1157-1177.

Temmerman, M., Ogbe, E., Manguro, G., Khandwalla, I., Thiongo, M., Mandaliya, K. N., Dierick, L., Macgill, M. & Gichangi, P. 2019. The gender-based violence and recovery centre at Coast Provincial General Hospital, Mombasa, Kenya: An integrated care model for survivors of sexual violence. *PLoS medicine,* 16.

Tesfaye, G., Chojenta, C., Smith, R. & Loxton, D. 2018. Application of the Andersen-Newman model of health care utilization to understand antenatal care use in Kersa District, Eastern Ethiopia. *PloS one,* 13**,** e0208729.

TFSOA 2013. Multisectoral SOPs for prevention and response to sexual violence-Kenya.

Tran, T. D., Nguyen, H. & Fisher, J. 2016. Attitudes towards intimate partner violence against women among women and men in 39 low-and middle-income countries. *PloS one,* 11**,** e0167438.

Tsai, A. C., Weiser, S. D., Dilworth, S. E., Shumway, M. & Riley, E. D. 2015. Violent victimization, mental health, and service utilization outcomes in a cohort of homeless and unstably housed women living with or at risk of becoming infected with HIV. *American Journal of Epidemiology,* 181**,** 817-826.

Tsai, A. C., Wolfe, W. R., Kumbakumba, E., Kawuma, A., Hunt, P. W., Martin, J. N., Bangsberg, D. R. & Weiser, S. D. 2016. Prospective study of the mental health consequences of sexual violence among women living with HIV in rural Uganda. *Journal of Interpersonal Violence,* 31**,** 1531-1553.

Ullman, S. E. & Peter-Hagene, L. 2014. Social reactions to sexual assault disclosure, coping, perceived control, and PTSD symptoms in sexual assault victims. *Journal of Community Psychology,* 42**,** 495-508.

Un Women 2013. Elimination and prevention of all forms of violence against women and girls. *2013 Commission on the Status of Women. Agreed Conclusions. http://www2. unwomen. org/~/media/headquarters/attachments/sections/csw/57/csw57-agreedconclusions-a4-en. pdf,* 1.

Undie, C., Mugisha, F., Kahega, E. & Askew, I. 2012. A Review and Evaluation of Multi-Sectoral Response Services ("One-Stop Centers") For Gender-Based Violence in Kenya And Zambia.

UNFPA 2010. Health sector response to gender-based violence Case Studies of the Asia Pacific region. Bangkok: UNFPA.

UNFPA 2015. Multi-sectoral response to GBV an effective and coordinated way to protect and empower GBV victims/survivors.

UNICEF 2003. Sexual and Gender-Based Violence against Refugees, Returnees and Internally displaced Persons-Guidelines for Prevention and Response. United Nations High Commissioner for Refugees Geneva.

UNICEF 2009. Thuthuzela Care Centres.

UNICEF 2012. Violence against children in Kenya: findings from a 2010 National Survey. *Nairobi: UNICEF, Centers for Disease Control and Prevention & Kenya National Bureau of Statistics*.

UNICEF 2014a. Hidden in plain sight. *A statistical analysis of violence against children. New York: United Nations*.

UNICEF 2014b. A statistical snapshot of violence against adolescent girls. *New York: UNICEF*.

United Nations 2005. The Economic Costs of Violence Against Women: An Evaluation of the Literature. Geneva: UN.

Unwomen 2013. Advancing Gender Equality: Promising practices, UN Millennium Development Goals Achievement Fund, Available at: http://www.unwomen.org/mdgf/downloads/MDG-F_CaseStudies.pdf.

Valls, R., Puigvert, L., Melgar, P. & Garcia-Yeste, C. 2016. Breaking the silence at Spanish universities: findings from the first study of violence against women on campuses in Spain. *Violence against women,* 22**,** 1519-1539.

Velzeboer, M., Ellsberg, M., Arcas, C. C. & García-Moreno, C. 2003. *Violence against women: the health sector responds*, Pan American Health Organization, Pan American Sanitary Bureau.

Vidu, A., Schubert, T., Muñoz, B. & Duque, E. 2014. What students say about gender violence within universities: Rising voices from the communicative methodology of research. *Qualitative Inquiry,* 20**,** 883-888.

Vidu Afloarei, A. 2017. *Networks of Solidarity: Student mobilizations against sexual violence in universities.* Doctoral Universitat de Barcelona.

Wachter, K., Murray, S. M., Hall, B. J., Annan, J., Bolton, P. & Bass, J. 2018. Stigma modifies the association between social support and mental health among sexual violence survivors in the Democratic Republic of Congo: implications for practice. *Anxiety Stress Coping,* 31**,** 459-474.

Waki, P. N. 2008. *Report of the Commission of Inquiry into Post Election Violence (CIPEV)*, Government Printer.

Wallis, C.R. and Woodworth, M.D., 2020. Child sexual abuse: An examination of individual and abuse characteristics that may impact delays of disclosure. *Child Abuse & Neglect*, *107*, p.104604.

Wangamati, C. K. 2014. *Quality of post rape care given to sexually abused minors: A qualitative study of Homa Bay District Hospital, Homa Bay County in Western Kenya.*

Wangamati, C. K., Gele, A. A. & Sundby, J. 2017a. Post Rape Care Provision to Minors in Kenya: An Assessment of Health Providers' Knowledge, Attitudes, and Practices. *Journal of Interpersonal Violence*.

Wangamati, C. K., Gele, A. A. & Sundby, J. 2017b. Post rape care provision to minors in Kenya: an assessment of health providers' knowledge, attitudes, and practices. *Journal of Interpersonal Violence***,** 0886260517696863.

Wangamati, C. K., Sundby, J. & Prince, R. J. 2018. Communities' perceptions of factors contributing to child sexual abuse vulnerability in Kenya: a qualitative study. *Culture, Health & Sexuality,* 20**,** 1394-1408.

Wangamati, C. K., Thorsen, V. C., Gele, A. A. & Sundby, J. 2016. Postrape care services to minors in Kenya: are the services healing or hurting survivors? *International Journal of Women's Health,* 8**,** 249.

Ward, J. & Marsh, M. Sexual violence against women and girls in war and its aftermath: Realities, responses and required resources. Symposium on Sexual Violence in Conflict and Beyond, 2006. 23.

Warshaw, C. & Alpert, E. 1999. Integrating routine inquiry about domestic violence into daily practice. *Annals of Internal Medicine,* 131**,** 619-620.

Weiss, K. G. 2010. Male sexual victimization: Examining men's experiences of rape and sexual assault. *Men and Masculinities,* 12**,** 275-298.

Weitzman, A., Cowan, S. & Walsh, K. 2017. Bystander Interventions on Behalf of Sexual Assault and Intimate Partner Violence Victims. *J Interpers Violence***,** 886260517696873.

Wentz, E. & Keimig, K. 2019. Arrest and Referral Decisions in Sexual Assault Cases: The Influence of Police Discretion on Case Attrition. *Social Sciences,* 8**,** 180.

WHO. 2008. *Primary health care: now more than ever*, World Health Organization.

WHO 2013. *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*, World Health Organization.

WHO 2014. *Global status report on violence prevention 2014*, World Health Organization.

WHO 2017. *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. Geneva: World Health Organization*

WHO & UNHCR. 2004. Clinical Management of Rape Survivors.

Williamson, V., Butler, I., Tomlinson, M., Skeen, S., Christie, H., Stewart, J. & Halligan, S. L. 2017. Caregiver Responses to Child Posttraumatic Distress: A Qualitative Study in a High-Risk Context in South Africa. *Journal of traumatic stress,* 30**,** 482-490.

Wirtz, A. L., Pham, K., Glass, N., Loochkartt, S., Kidane, T., Cuspoca, D., Rubenstein, L. S., Singh, S. & Vu, A. 2014. Gender-based violence in conflict and displacement: qualitative findings from displaced women in Colombia. *Conflict and Health,* 8**,** 10.

Wolitzky-Taylor, K. B., Resnick, H. S., Mccauley, J. L., Amstadter, A. B., Kilpatrick, D. G. & Ruggiero, K. J. 2011. Is reporting of rape on the rise? A comparison of women with reported versus unreported rape experiences in the National Women's Study-Replication. *Journal of Interpersonal Violence,* 26**,** 807-832.

World Health Organization 2002. *The world health report 2002: reducing risks, promoting healthy life*, World Health Organization.

World Health Organization 2003. Guidelines for medico-legal care for victims of sexual violence. Geneva: WHO.

World Health Organization 2004. Clinical Management of Rape Survivors: Developing Protocols for use with refugees and internally displaced persons.

World Health Organization 2009. Changing cultural and social norms that support violence.

World Health Organization 2013. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, World Health Organization.

World Health Organization 2016. Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children.

World Health Organization 2017. Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. *Responding to children and adolescents who have been sexually abused: WHO clinical guidelines.*

Wuest, J., Merritt-Gray, M., Lent, B., Varcoe, C., Connors, A. J. & Ford-Gilboe, M. 2007. Patterns of medication use among women survivors of intimate partner violence. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, 460-464.

Yuan, N. P., Koss, M. P. & Stone, M. 2006. Current trends in psychological assessment and treatment approaches for survivors of sexual trauma.

Zilkens, R. R., Smith, D. A., Kelly, M. C., Mukhtar, S. A., Semmens, J. B. & Phillips, M. A. 2017a. Sexual assault and general body injuries: A detailed cross-sectional Australian study of 1163 women. *Forensic science international,* 279**,** 112-120.

Zilkens, R. R., Smith, D. A., Phillips, M. A., Mukhtar, S. A., Semmens, J. B. & Kelly, M. C. 2017b. Genital and anal injuries: A cross-sectional Australian study of 1266 women alleging recent sexual assault. *Forensic Science International,* 275**,** 195-202.

Zungu, L. I., Salawu, A. O. & Ogunbanjo, G. A. 2010. Reported intimate partner violence amongst women attending a public hospital in Botswana. *African Journal of Primary Health Care & Family Medicine,* 2.