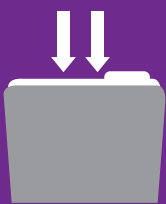




IMPROVING THE COLLECTION, DOCUMENTATION AND UTILISATION OF MEDICO-LEGAL EVIDENCE IN KENYA



Collection



Documentation



Utilisation



Evidence

STUDY COLLABORATORS:



Building Partnerships
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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AS	Anal Swab
CCC	Comprehensive Care Clinic
CME	Continuous Medical Education
DPP	Director of Public Prosecution
DRH	Division of Reproductive Health
EC	Emergency Contraception
GBV	Gender Based Violence
GIZ	Gesellschaft für Internationale Zusammenarbeit
HCW	Health Care Worker
HIV	Human Immuno-Deficiency Virus
HVS	High Vaginal Swab
LVCT	Liverpool VCT, Care and Treatment
OB	Occurrence Book
OCPD	Officer Commanding Police Division
OPD	Outpatient Department
OR	Operations Research
PEP	Post Exposure Prophylaxis
PRC	Post Rape Care
STIs	Sexually Transmitted Infection
SV	Sexual Violence
SVRI	Sexual Violence Research Initiative
WHO	World Health Organization

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EXECUTIVE SUMMARY

Sexual violence remains a global public health problem and a violation of multiple human rights which can negatively impact the physical, social and mental health of survivors, both immediately and in the long term.

The collection and documentation of medico-legal evidence is an important element of response to sexual violence because it is central to the success of prosecution efforts and positive legal outcomes for sexual violence survivors in Kenya and the world over. . However, significant gaps exist in how medico-legal evidence is collected and recorded in Kenya.

The objectives of this study were:

- To develop and test the feasibility of using a locally assembled rape kit as a strategy for improving forensic evidence collection and documentation within health facilities; and
- To develop mechanisms for ensuring that such forensic evidence is recorded on the police medical examination ('P3')⁴ form and entered into legal evidence at the police station.

The study used a pre and post-intervention design with a comparison arm to compare the level of evidence collection and documentation across intervention and comparison sites using a rape kit with collection and documentation without a rape kit. The kit was piloted in Kitui District Hospital of Kenya from 2010 to 2012 by LVCT, in collaboration with the Division of Reproductive Health (DRH) and The Ministry of Health. Key informant interviews were conducted in the intervention site to elicit health care provider experiences in using a locally-assembled rape kit to aid in evidence collection.

Summary of findings:

- Utilisation of the rape kit aids in eliminating the need for the survivor to be examined by more than one health care provider, which has been shown to increase survivors' trauma.
- The improved utilisation of the post-rape care (PRC) form⁵ strengthens use of health facility documentation as evidence within the court system.
- Improved evidence collection using the locally assembled rape kit is feasible through the provision of essential equipment and reagents as stipulated within the national guidelines on the management of sexual violence.
- Training on medico-legal documentation, namely, PRC and P3 forms, greatly enhanced level of utilisation of both forms by health care providers and police.

4 The P3 form is a legal document obtained from the police stations for use by health care providers in documenting management of any assault and sexual violence cases reported to the health facility.

5 Sexual Offences (Medical Treatment) Regulations, 2012. On 16 Nov the PRC form was gazetted by the Minister for Public Health and Sanitation via Legal Notice No. 133. The gazettelement therefore requires that medical practitioners utilise the PRC form in documenting forensic examinations and evidence collection.

- Lack of storage facilities within the police station for evidence collected by both the police and health care workers remains a barrier to systematic evidence collection of non-biological forensic evidence.
- Delayed reporting by survivors of sexual violence to either the police station or health facility remains a great impediment to evidence collection and medical management. This has resulted in difficulties for the criminal justice system to effectively prosecute cases of sexual violence due to lack of sufficient corroborative evidence

Recommendations:

- Scaled up utilisation of the rape kit in health facilities can be achieved through inclusion of evidence collection Standard Operating Procedures (SOPs) in the multi-sectoral guidelines and operating protocols currently being developed by the Kenya Sexual Offences Taskforce. This also necessitates the development of quality control and assurance mechanisms to safeguards quality of evidence collected by the different sectors.
- There is need for the government ministries to jointly develop a training package to be used in facilitation of multi-sectoral trainings of service providers.
- All health and legal sector pre-service curricula should include a module on importance of proper documentation in management of survivors. This will reduce the amount of resources currently invested in on the job training in an environment where staff turnover of staff in health facilities is very high.
- The Ministry of Health should develop protocols to govern the management of survivors of sexual violence who present to health facilities beyond the 72 hours required for PEP efficacy.

BACKGROUND

Sexual violence (SV) remains a global public health problem and a violation of multiple human rights. Sexual violence can negatively impact on the physical, social and mental health of survivors, both immediately and in the long term. It is associated with many adverse reproductive and sexual health outcomes that include early and unwanted pregnancy, unsafe abortion, sexually-transmitted infections (STIs), including HIV/AIDS, and genital injuries (Jewkes and Dartnall, 2008). It is also associated with and results in negative social and mental health outcomes, including long-term psychological and physical trauma, feelings of anger guilt and shame strained relationships with family, friends, and intimate partners, limited emotional support and increased discrimination from friends and family (Golding, et al 2002; Littleton and Breitkopf, 2006). It is assumed that some of the negative outcomes of SV can be ameliorated through the provision of appropriate post-rape care (PRC) services (Bletzer and Koss, 2006). However, lack of evidence of the effectiveness of existing interventions hinders the development of quality evidence based policies, services and programmes for both child and adult survivors of sexual violence (SVRI, 2006).

Elements of the health sector response to sexual violence include: protection of the survivor from harm; medical care with a focus on treatment and documentation of injuries; comprehensive history taking and a physical examination; performing laboratory tests and prophylactic treatment; psychosocial support; and provision of on-going follow up and support (PAHO, 2003).

The collection and documentation of medico-legal evidence is an especially important element of this response because it is central to the success of prosecution efforts and positive legal outcomes across the world (Human Rights Watch 2009). Existing literature suggests that cases of sexual violence where evidence is collected and well documented are more likely to move forward in the criminal justice system than cases where evidence is not collected (Jina, 2006). Successful utilisation of medico-legal evidence⁶ is however dependent on three factors:

- 1) The collection of samples;
- 2) Documentation of examination and laboratory results by health professionals; and
- 3) Entry of that evidence into police records. A review by Parnis and Du Mont (2002) indicated that in many cases the only medical evidence that informed prosecution of cases of SV was documented injury.

While the importance of forensic evidence collection is widely recognised, research demonstrates that the collection of medico-legal evidence that is required by the criminal justice system for corroborative purposes has been inconsistent, limited in quality or at times non-existent (Du Mont and White, 2008). In Kenya, research conducted by LVCT found that while the criminal justice system relies heavily on medico-legal evidence collected by health care providers, significant gaps exist in how that evidence is collected and recorded (Ajema. et al., 2009). The gaps include: use of the generic term “assault” in documenting cases reported, instead of the specific type of SV as stipulated in the sexual offences act; shortage or absence of the equipment required and skills in their usage to collect samples; diversity in the type of evidence collected from survivors; lack of understanding of the national documents to be used in capturing survivor data; and lack of storage facilities for evidence collected.

⁶ Medico-legal evidence refers to a wide range of specimens collected by medical personnel to assist with the criminal investigations process. It includes biological samples, non-biological specimens, extra-genital and ano-genital injuries, and the emotional state of the survivor at the time of the forensic examination. Biological samples include: semen, blood, clothing, hair, and saliva, foreign materials on clothing or body, and drugs. The term ‘forensic evidence’ is commonly used interchangeably with medico-legal evidence, and refers to the same thing (WHO, 2003; Mugo N and Kilonzo N, 2005; SVRI, 2006).

Ajema et al., 2009 identified three major limitations to the effectiveness of medico-legal evidence in positively informing prosecution efforts in Kenya:

- 1. Lack of the required evidence collection tools.** Health care providers lacked the essential tools and equipment to facilitate the immediate retrieval, analysis and storage of evidence such as blood, urine, high vaginal swabs (HVS) and foreign materials on the body or clothing of the survivor during the initial comprehensive examination of survivors. This has resulted in health care workers not collecting relevant and comprehensive evidence especially from children and male survivors. Where equipment may be available, some health providers lack the skills in their usage to collect evidence from children. The Kenyan national guidelines on the medical management of survivors of sexual violence clearly state the types of evidence to be collected but do not specify the type of equipment required to do this.
- 2. Poor documentation of collected evidence by the health care provider.** Health care providers are required to complete the Post-Rape Care (PRC) form to record the survivor's examination details and the results of the laboratory analysis (see Annex 1). At the time of conducting this study, the PRC form was yet to be gazetted making its admissibility in court contentious. The form is produced in triplicate: 1) the original white copy of the PRC form alongside the Kenya Police medical examination form (also known as the 'P3' form), constitute part of the police records; 2) the duplicate green copy of the PRC form is given to the survivor; 3) the yellow copy is retained in health facility records. The PRC forms are consistently incomplete due to limited evidence collection procedures and recording errors or omissions by health care workers.
- 3. Failure in adducing health facility medico-legal documentation as evidence in the police station.** Presentation of health facility medico-legal documentation as evidence at police stations is the third critical step in the chain of custody of evidence. The evidence collected at the health facility should be entered into the police files and can be used for prosecution. The police medical report (P3) form is the primary evidence document admissible in court (Annex 2). The revised PRC form of 2011 allows for key elements of medico-legal evidence captured on this form to be entered directly onto the P3 form. This reduces the paperwork required for each case and circumvents disagreements between the police and health care workers. However, copies of PRC forms rarely get filed within the police records alongside the P3 forms. This could be attributed to many factors, including :1) lack of knowledge by both police and Health Care Workers (HCWs) on how the original copy of the PRC form gets delivered to the police; or (2) failure by the HCWs to accurately or duly fill in all the required variables on the PRC form.

In response to the three main barriers, the study aimed to improve the collection, documentation and utilisation of medico-legal evidence in Kenya in order to facilitate improved health and legal outcomes for survivors of sexual violence.

Overview of the Kenya Public Health Care System

The Kenya public health care system consists of the following levels of health facilities: national referral hospitals, provincial general hospitals, district hospitals, health centres, and dispensaries. The role of each of these health facilities is as outlined below:

- **National and provincial hospitals;** specialise in the provision of diagnostic, therapeutic, and rehabilitative services. They also serve as referral hospitals for their district hospitals in addition to providing specialised care to survivors
- **District hospitals;** concentrate on the delivery of health care services required by survivors. They are the first point of contact for the delivery of comprehensive PRC services. District hospitals are required to provide the first level of care to survivors with focus on prophylactic treatment; medical management; counselling; injury management; detailed history taking, evidence collection and documentation ; referral to the police; and presentation of evidence in court (when called upon).
- **Health centres and dispensaries;** offer preventive and curative services and manage injuries resulting fromSV and obtain a detailed history, examination, and documentation before referring survivor for further examination and prophylactic treatment.

STUDY DESIGN AND METHODOLOGY

Objectives

The study objectives were to:

1. Develop and test the feasibility of using a locally assembled rape kit as a strategy for improving forensic evidence collection and documentation on the PRC form within health facilities.
2. Develop mechanisms for ensuring that such forensic evidence is recorded on the P3 form and entered into legal evidence at the police station.

The study was conducted in 2010/11 and involved the collection of records from health facilities and police stations; training of police and health care providers on utilisation of national documentation in delivery of post rape care services; and training of health care providers on the collection of evidence using a locally assembled rape kit. It was anticipated that the rape kit would aid health care workers to collect the minimum corroborative evidence required in the medico-legal management of SV cases, especially since DNA testing (which may be the ideal standard of proof) is too costly to be applied as a standard in resource poor settings in Kenya.

It was hypothesised that, at the conclusion of the intervention, medico-legal evidence collection and documentation in the intervention site would show greater improvement than would be the case in the comparison site. The indicators for measuring “improvement” included: *number of cases with the correct type of sexual violence documented; documentation of complaint presented at both the police station and health facilities; ability to track each survivor in all the PRC documentation protocols used in health facilities.*

Study design

This was an operations research (OR) study to assess the feasibility of an intervention aimed at improving forensic evidence collection and utilisation.

A quasi-experimental design with intervention and comparison arms was employed to test the study hypothesis. The following outcomes were measured at the intervention and comparison sites: *level of utilisation of the PRC and P3 forms for documentation; types of evidence collected using the rape kit; and proportion of SV survivor complaints documented in the police and health facility records.*

Study sites

The study was carried out in two districts, with Kitui District Hospital and Kitui Police Station acting as the intervention site, while Rachuonyo District Hospital and Rachuonyo Police Station served as the comparison site.

The intervention and comparison sites were selected because of their history with LVCT. LVCT had conducted a previous study entitled “*Practices on evidence collection, preservation, and analysis,*” at these sites, which identified the need for piloting a locally assembled rape kit.

Rachuonyo was selected as the comparison site due to it having been an LVCT post rape care services supported site since 2005. The selection of this site would help inform the level of provision of services as per the national set standards.

Kitui was selected as the intervention site due to its proximity to Nairobi where most of the representatives from government departments involved in the national policy technical working groups and taskforces (mainly the Division of Reproductive Health's Gender and Sexual and Reproductive Health working group; and the Sexual Offences Act implementation Task force) are based. Close proximity to Nairobi was also considered necessary to facilitate the close monitoring of the utilisation of the rape kit and documentation protocols by LVCT's PRC officers.

The intervention site piloted the rape kit and conducted joint trainings of police, health care providers and prosecutors over a period of 7 months, while the comparison site delivered their usual PRC services over the same period.

Data Collection

The study was undertaken over a period of 18 months as described below:

1. Record Reviews

Baseline and end line retrospective record reviews were conducted in October 2010 and January 2012 respectively, within intervention and comparison site health facilities and police stations. The purpose of these reviews was to help establish the extent to which the examining clinicians utilised the PRC form in documenting evidence obtained from the survivor, and the care given. The documents reviewed included the available PRC forms, P3 forms, laboratory and trauma counselling registers. (Annex 3)

The documents were reviewed for the following outcomes: *level of utilisation of the PRC and P3 forms for documentation; types of evidence collected using the rape kit; and proportion of SV survivor complaints documented in the police and health facility records.*

a) Health facility records

In each health facility, PRC forms were reviewed for SV survivors who presented in the 25-month period between January 1, 2010 and 31st January 2012. The aim of this review was to establish the extent to which the examining clinician(s) utilised the PRC form to capture details of the survivor, the assault and medico-legal care given. This documentation was used as a proxy measure of forensic evidence collection procedures, since data on the actual evidence collection could not be adequately captured.

The data captured from the health facility documents included:

- Survivor demographics (with exception of the survivor name, contact details or other unique identifiers for confidentiality of the patient)
- Type of SV reported
- Type of evidence collected (blood, urine, clothing, etc.) and by what level of provider
- Clinical services provided to the survivor
- Number of PRC and P3 forms (if available) with signatures of service providers
- Whether referral was made by the clinician to the police
- Name of police station that issued the P3 form

b) Police Records

The researchers, with the help of assigned police officers in two police stations, collected statistics of the SV cases reported to the police station, and assessed whether the P3 forms were filled. The sample included all SV cases reported to the station between January 1, 2010 and 31st January 2012.

The data captured from the police records included:

- Survivor demographics (with exception of the survivor name, contact details or other unique identifiers for confidentiality of the survivor)
- Type of SV reported
- P3 form filled and signed by both police and clinician

Since the names or unique identifiers of survivors were not collected by the researchers, it was not possible to track individual cases between the health facilities and police stations.

2. Primary data: Key Informant Interviews

Key informant interviews (KIIs) were undertaken with five of the nine health care providers who provide PRC services at the intervention site to document their experiences in using the rape kit and documentation protocols. Purposive sampling was used in selecting respondents from the health facilities and police stations. At the health facility, the focus was only on clinicians involved in evidence collection, documentation and analysis. The health care providers interviewed included doctors, clinical Officers, nurses and laboratory in-charges (Annex 4). At the police station, the study respondents were four officers stationed at the gender desks. The interviews were carried out in October 2010 and November 2011.

3. Service delivery data: Collection of monthly service statistics by PRC officers

On a monthly basis, LVCT PRC officers in both intervention and comparison sites collected routine monitoring data from the hospitals and police stations in order to establish the number of survivors attended to, level of utilisation of the rape kit in evidence collection, and utilisation of P3 and PRC forms for documentation (Table 1). LVCT prepared a monthly monitoring checklist to ensure that all data was properly collected and recorded (Annex 3). Where data were not well captured and documented, the LVCT PRC officers identified gaps and did an on-the-job sensitisation of the clinicians during the Continuous Medical Education (CME) sessions using the national guidelines on the management of SV.

At the health facilities, PRC officers carried out a review of the facilities' PRC registers, PRC forms and P3 forms to identify all cases of SV reported. The PRC officers then compiled the PRC and P3 forms completed at the facilities on a monthly basis and noted the areas that required improvement. These were discussed in face to face meetings between the research team, the PRC officers and the health care providers.

At the police station, PRC officers, with support from the police officers stationed at the gender desk, obtained information on the number of SV cases reported, and those that were referred to the hospital for filling in of the P3 form. It was not possible for the PRC officers to trace the number of survivors for whom both the P3 and PRC forms were filed at the police station, given that all these records are immediately transferred to the courts once compiled by the investigating police officer.

Data management and analysis

All quantitative data were entered into EPI info 7 and analysed through cross tabulations using SPSS version 13. Data were cleaned and any errors identified corrected through a physical check of the data sources. Analysis of the data took into account the study objectives and expected outcomes at each phase of the study.

The following were the key variables analysed: demographic information of the survivors; samples collected; level of utilisation of the PRC and P3 forms; and documentation of management accorded to the survivors in the laboratory register, counselling registers and PRC form.

All in-depth interviews were recorded, transcribed, then analysed using NVIVO 8.

Table 1: Summary of Study Design

	Baseline	Intervention		End line
Site	Baseline data collection	Intervention	Routine data collection	Final evaluation
Kitui: Intervention	Retrospective record review for the period January 1, 2010-September 30, 2010 of: • PRC and P3 forms in hospital files • PRC and P3 forms in police files	Development and implementation of locally-assembled rape kit Training of health care workers and police on utilization of the rape kit and proper documentation using PRC and P3 forms	Collection of monthly health and police service statistics by PRC officers Bi quarterly data collection visits by LVCT research staff (KILs conducted with HCWs)	Analysis of intervention data, intervention vs. comparison sites Key evaluation questions: • Did the intervention improve the collection of medico-legal evidence? • Did the intervention improve the documentation of medico-legal evidence within the health facility? • Did the intervention improve the rate at which medico-legal evidence is entered into evidence at the police station? • Can the intervention be scaled-up?
Rachuonyo: Comparison	Retrospective record review for the period January 1, 2010-September 30, 2010 of: • PRC and P3 forms in hospital files • PRC and P3 forms in police files	No intervention (<i>facilities receive updated PRC and P3 forms</i>)	Collection of monthly health and police service statistics by PRC officers Bi quarterly data collection visits by LVCT research staff (KILs conducted with HCWs)	

Ethical Considerations

Ethical and research clearance for the study was provided by the Kenya Medical Research Institute. Prior to the commencement of the study, the study objectives and expected outcomes were shared with the Division of Reproductive Health, The Police Department; Police Training Institute, the Director of Public Prosecutions office, The Government Chemist; the officers commanding the targeted police stations; and the administrators of the targeted health facilities. This was to ensure their buy in during the review of the assembled kit and training of service providers on evidence collection and documentation. Individual informed consent was obtained from all participants before the interviews. Consent was also obtained from the health facility in charges before data was retrieved from the P3 forms, PRC forms and registers.

The study team was trained on ethical issues to ensure their understanding of informed consent, its meaning, and process; the importance of protecting the privacy of subjects; and the requirement to maintain the confidentiality of the information obtained from respondents and from the record reviews.

THE INTERVENTION

Prior to the commencement of the baseline data collection, meetings were held between LVCT, the Division of Reproductive Health (DRH), the Government Chemist and the Director of Public Prosecution's (DPP) office to develop consensus on the study methodologies to be employed for data collection and records review. These meetings were aimed at obtaining consensus on the contents of the rape kit to be piloted during the intervention. Representatives from the identified Government departments negotiated and built consensus on their role in the training of service providers on evidence collection and documentation.

Analysis of baseline data was used to develop the training modules to build the capacity of both the police and clinicians on evidence collection and documentation. The development of the training modules was led by LVCT but was a consultative process involving all the above mentioned stakeholders. The intervention phase lasted 7 months.

The intervention consisted of three components: 1) development of a locally-assembled 'rape kit' to improve the collection of evidence; 2) training health care workers to better document their examinations on the PRC and P3 forms; and 3) training health care providers and police on strategies for increasing survivors' likelihood to return completed PRC and P3 forms to the police.

The following specific activities were undertaken as part of the intervention.

a) Consultative meetings between key stakeholders

The researchers had meetings with stakeholders to agree on the scope and purpose of the proposed intervention, including developing consensus on the elements of the rape kit to be tested and the content of service provider training (for both health care workers and police).

b) Refinement of a locally-assembled rape kit

A core element of the intervention was the development and utilisation of the rape kit in examining survivors presenting at the health facility. In a previous study, LVCT worked with the DRH and Government Chemist to identify the core components of a locally-assembled rape kit drawn from supplies which are routinely available at district hospitals. During this study, the proposed contents of the rape kit were presented to the Government Chemist, forensic analysts, the DRH Gender and Reproductive Health Technical Working Group and the medical doctors in Kitui District Hospital and consensus was achieved for their utilisation in this study. The contents of the rape kit and quantity of each are detailed in Table 2.

Supplies adequate to assemble 100 rape kits were purchased using study funds. LVCT's Post Rape Care (PRC) Officers who are either clinical officers or nurses assembled and distributed the kits to the hospital during monthly visits. A total of 50 rape kits were utilised at the intervention site during the 7 month intervention period.

Table 2: Contents of the Rape Kit

Description of item	Quantity per kit	Purpose
Powder free gloves	1	To avoid contamination.
Sterile gloves	2	For the sterile procedures such as collecting HVS
Stick swabs	6	For taking the HVS and/or anal swabs
Masking tape	1	For sealing the brown envelopes in which the specimens have been stored
Brown envelopes for collecting samples	20	For proper storage of collected specimens
Tape Measure	1	To measure the physical injuries, if any, that are found on the survivor
Needles and syringes	3	Collection of blood samples
Urine bottles	1	Collection of urine samples
Vercutainer tubes	1	Collection of blood samples
Speculum	1	Collection of specimens from the vaginal cavity
Labels	10	For labelling the brown envelopes with the details of the specimens stored inside
Pregnancy testing kit	1	To test for pregnancy
Seal lock bags	20	For proper storage of collected specimens
Green towels	2	One for wiping hands during the sterile procedure One for placing beneath the patient's buttocks

The rape kit was made available at the outpatient department (OPD) of the intervention site in order for the health provider to collect evidence from the survivor whilst collecting a detailed history of the complaint. The placement of the kit at the OPD was also informed by the need to prevent different service providers from inflicting more trauma on the survivor by having the evidence collection and head to toe examination undertaken by different HCWs.

In order to minimise incidents where the survivor would have to queue at the laboratory for samples to be retrieved, the specimens collected at the outpatient department were transferred to the laboratory by one of the hospital support staff, and the results delivered back to the doctor by the laboratory technician.

c) Training of health care workers and police at the intervention sites

Training was undertaken by a team of 5 resource persons drawn from the DRH, Government Chemist, the DPP's office and LVCT PRC Programme Officers. A total of 42 participants from the intervention site attended the training (see Annex5).

The following criteria were used to select the participants:

- **Health care workers:** Only doctors, nurses and clinical officers involved in evidence collection and documentation were selected by the Medical Superintendent
- **Laboratory Technicians:** Those involved in analysis of evidence and filling in of the laboratory PRC register
- **Police officers stationed at the gender desk** and crime unit in Kitui Police Station and its environs as selected by the Officer Commanding a Police Division(OCPD)
Prosecutors: Focus was on investigators who had ever handled a case of sexual violence. These were selected by the OCPD on behalf of the Chief prosecutor

The following modules were covered during the training:

- Forensic examination
- Utilisation of the locally-assembled rape kit
- Utilisation of the national PRC form and P3 form for documentation of evidence collected and referrals between the police and health facility.

The training also aimed to equip police officers with knowledge of their role in providing PRC services, including the provision of the P3 forms to survivors, how to fill in the P3 form, and their responsibility in enlightening the survivors on the importance of having the completed forms returned to the police.

The police officers interviewed indicated how this multi-sectoral training had aided in the level of collaboration with the HCWs

Interviewer: *Do you get copies of the PRC form and the P3 form from the hospital when you refer people there?*

Respondent (Police): *When we refer, in fact these days it is easy. After you finish filling it (P3 form), the victim goes with it (to the hospital), they are treated quickly and then they return it, and then now you shall just go there and collect the form (PRC form). And when you go there, it is actually something that is planned for. So there is no problem*

Interviewer: *So according to you, has there been any change after the training?*

Respondent (Police): *I have seen that it has made work easier between us and the health providers at the hospital*

Gender Officer-Intervention Site

The training also enhanced referral linkages between the police and health facility

Respondent (Police): *"..... In fact since the training, it has caused a good relationship between us and the hospital, we are like partners. So things are going well. Even Mutuko, the doctor himself, if he sees something he calls us and we talk. So there is no problem there."*

d) Development of a documentation algorithm

To aid HCWs in establishing the types of information to be documented and tools to be used at different service delivery points, an algorithm highlighting was developed during the study. The developed documentation checklist was reviewed by members of the Division of Reproductive Health's Reproductive Health Working Group before it was utilised in the review of the national clinical algorithm chart. This was then shared with the intervention site to aid in documentation.(Annex 6)

FINDINGS

A. Survivor Characteristics

1. Sex of SV survivors attended to at the health facilities

A total of 501 SV survivors reported to the intervention (66%) and comparison (34%) facilities from 1st January 2010 up to 31st January 2012 period (Table 3). Similar to findings from other studies, the majority of SV survivors were female.

Table 3: Number of Survivors per Health Facility

Health facility	Female	Male	Total
Intervention	275 (63.5%)	56 (82.4%)	331(66.1%)
Comparison	158 (36.5%)	12 (17.6%)	170 (33.8%)
Grand Total	433(100%)	68 (100%)	501 (100%)

2. Distribution of survivors by age group

Similar to previous studies, the majority of survivors of sexual violence in this study were under 18 years (Table 4). Of these, 11% (51) were children under 5 years.

Table 4: Survivors by Age Group in Health Facility and Police Records

	Health facility records(n=501)		Police records(n=119)	
Ages n=501		Comparison site	Intervention site	Comparison site
Below 18 years	198	117	59	20
Above 18 years	117	32	13	8
TOTAL	315	149	72	28

37 survivors did not have ages indicated in the health records, while 19 survivors did not have their ages indicated in the police records

Data from the police occurrence book⁴ also indicated that many of the cases reported to the police station were of survivors under 18 years in both the intervention and comparison site

It was not possible to establish cross referrals between the health facilities and police stations using records, as names of survivors were not captured by the researchers for confidentiality purposes. Age and sex of the survivors were the only demographics captured by the researchers as shown in Table 5.

Majority of the survivors in both the intervention and comparison sites were female children. The intervention site saw an increase in the number of male cases reporting at the health facility between baseline and end line.

Table 5: Survivors by Gender and Age

	Comparison site		Intervention site		Total
Ages n=501	< 18 years	< 18 years	< 18 years	< 18 years	
Male	6	6	16	33	61
Female	109	40	168	86	403
TOTAL	115	46	184	119	464

37 survivors did not have ages indicated in the health records

⁴ An Occurrence Book (OB) is a notebook used by police to document all complaints lodged in at the police station.

3. Types of violence reported and recorded

The Sexual Offences Act, 2006⁵ provides definitions for different types of SV, namely: *rape, attempted rape, sexual assault, compelled or induced indecent acts, acts which cause penetration or indecent acts committed within the view of a child or person with mental disabilities, defilement, attempted defilement, gang rape, indecent act with child or adult, promotion of sexual offences with a child, child trafficking, child sex tourism, child prostitution, child pornography, exploitation of prostitution, trafficking for sexual exploitation, prostitution of persons with mental disabilities, incest by male persons and incest by female persons.*

During the baseline phase of the study, it was established that in most instances, health care providers did not to utilise the definitions provided for within the Sexual Offences Act to document the complaint presented. They instead documented the complaints presented based on where the penetration had occurred, or what object was used. For example, for sexual violations of women above 18 years, the complaint was documented as “penile/ vaginal,” while for men, it was documented as “penile/anal.”

Table 6: Types of SV Cases Reported at Baseline

Type of SV reported	Intervention site (N=67)	Comparison site (N=68)	Total (N=135)
Penile/Vaginal	36 (53.7%)	13 (19.1%)	49(36.3%)
Penile/Rectal	9 (13.4%)	0 (0.0%)	9 (6.7%)
Attempted Rape	3 (4.5%)	1 (1.5%)	4 (3.0%)
Sexually Assaulted	0 (0.0%)	1 (1.5%)	1(0.7%)

At end line, there was a change in the level of utilisation of correct SV terminologies as stipulated within the Sexual Offences Act in the intervention site. For the comparison site, there remained instances where providers used the term “rape” instead of “defilement” for cases reported by survivors under 18 years.

Table 7: Survivors by Type of SV Recorded at Health facility by Age

Type of Violation	Intervention site		Comparison site	
	Baseline	End line	Baseline	End line
Attempted Rape	5 (4)	3 (7)	4 (5)	0%
Defilement	46 (37)	7 (15)	18(24)	2(11)
Rape	74 (59)	36 (78)	54(71)	17 (89)
Total	125 (100)	46 (100)	76 (100)	19 (100)

This calls for more sensitisation of staff on the use of proper terminology as stipulated in the Sexual Offences Act.

Data captured from the records at the police gender desks for cases reported between 2010 and 2012 showed categorisation of the various forms of SV in the intervention site but not at the comparison site (Table 8). This could be attributed to the police officers in the comparison having not been sensitised on the different types of SV.

⁵ [http://www.kenyalawreport.co.ke/Downloads/Acts/Sexual%20Offences%20Act%20%20\(%203%20of%202006\)%202009.pdf](http://www.kenyalawreport.co.ke/Downloads/Acts/Sexual%20Offences%20Act%20%20(%203%20of%202006)%202009.pdf)

Table 8: Cases Documented at Rachuonyo and Kitui Police Stations

Site	Type of offences	Cases documented	Site	Type of offences	Cases documented
Intervention site	Attempted defilement	11	Comparison site	Sexual offences	28
	Attempted Rape	8			
	Defilement	35			
	Rape	7			
	Incest	6			
	Attempted Incest	3			
	Unnatural offences	5			
	Indecent assault	2			
	Total	77			28

B. Provision of Prophylactic Treatment

An analysis was undertaken to establish what prophylactic treatment was given to survivors who presented within or after the initial 72 hour period. Records collected at baseline and at end line indicated that there were instances where survivors were given prophylactic treatment despite reporting to the facility more than 72 hours after the assault.

It is not clear what informed decisions by health care workers to provide survivors (majority of them younger than 12 years) with PEP after 72 hours, but this may be attributed to lack of adequate information among HCWs on the efficacy of PEP within 72 hours.

An improved documentation of PEP and emergency contraception (EC) provided was observed in the intervention site. Of those who were provided with PEP at baseline in the intervention site, 52% had sought PRC services within 72 hours as compared to 80% at end line. Table 9 further shows that EC was provided to 81% as compared to 50% at baseline.

Table 9: Provision of PEP and EC to Survivors

Time of survivors' presentation	Intervention site N=331		Comparison site N=170	
	Baseline n (%)	End line n (%)	Baseline n (%)	End line n (%)
< 72	15 (38)	68 (67)	15 (83)	58 (91)
> 72	25 (63)	34 (33)	3 (17)	6 (9)
Total	40 (100)	102 (100)	18 (100)	64 (100)
PEP provided				
< 72	13 (52)	53 (80)	15 (100)	53 (95)
> 72	12 (48)	13 (20)	0(0)	3 (5)
Total	25 (100)	66 (100%)	15 (100)	56 (100)
EC provided				
< 120	2 (100)	30(94)	4 (100)	17 (100)
> 120	0 (0)	2 (6)	0(0)	0(0)
Total	2 (100)	32 (100)	4 (100)	17 (100)

C. Evidence Collection

According to the Kenya National Guidelines on the Management of Sexual Violence (2010), health care providers are required to collect two types of evidence:

- Evidence to prove that a sexual assault occurred; and
- Evidence to link the alleged assailant to the assault.

The Guidelines stress the importance of documenting evidence collected from survivors. The guidelines also provide specification of the type of samples to be obtained from survivors. These include collection of medical samples such as a high vaginal swab (HVS) to test for the presence of spermatozoa, collection of blood, urine and foreign materials on clothing or the body.

Table 10: Evidence Collected As Documented in PRC form

	Intervention site(n=331)		Comparison site(n=170)	
	Baseline	End line	Baseline	End line
Blood	73 (72%)	206 (96%)	38 (37%)	8 (18%)
Urine	52 (51%)	154 (72%)	38 (37%)	8 (18%)
External Swabs	—*	19 (9%)	3 (3%)	1 (2%)
HV/AS	61 (60%)	176 (82%)	14 (42.4%)	5 (11%)

**HCWs were not swabbing the outside of the genitalia area*

The above data shows an overall improvement in evidence collection within the intervention site.

At baseline, the health care workers were found to only collect evidence to prove that a sexual assault occurred. This scenario remained the same at end line, as providers at the intervention site, despite being trained on the importance of collection samples in duplicate for onward transmission to the Government chemist through the police, indicated the challenges this poses in terms of preservation, storage and transportation of the duplicate samples to the Government Chemist. The HCWs indicated that the police never obtain forensic evidence from the hospital for delivery to the government chemist for further analysis due to lack of transport and storage facilities at the police stations. It was also observed that the refrigerators available in the hospital laboratory are not adequate or spacious enough for long term storage of evidence before its delivery to the government chemist through the police. This was also corroborated during the in-depth interviews with the police

1. Evidence collection using a locally assembled kit

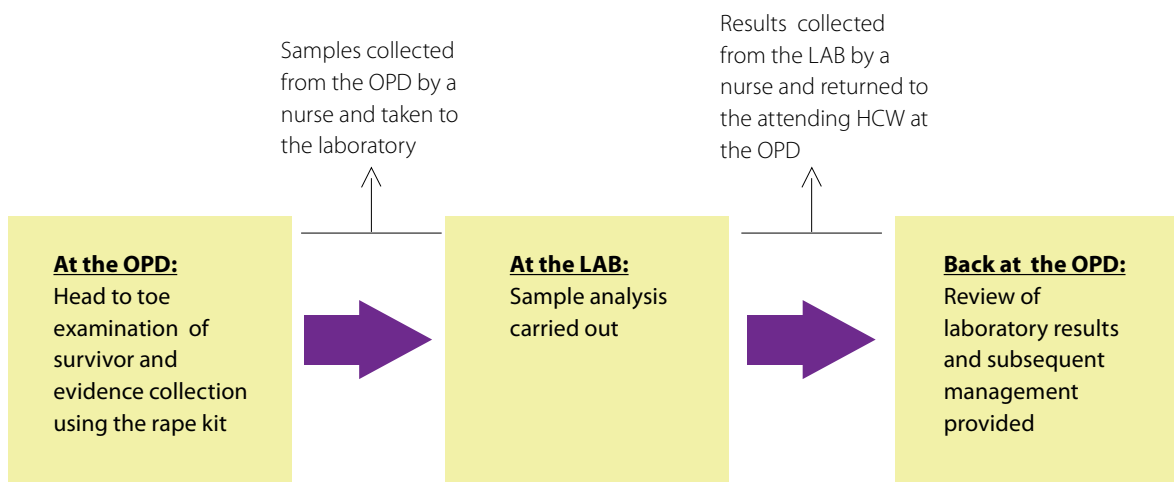
In a previous study (Ajema et al.,2009), the need for development of protocols that clearly stipulated the minimum evidence to be collected and for the sensitisation of service providers on documentation procedures required to maintain a chain of custody, was highlighted. These findings led to the development of the locally assembled rape kit whose feasibility of utilisation was assessed in this study.

A total of 100 kits were assembled through consultative meetings with representatives from targeted government ministries and service providers at the intervention site. All the kits were located within the medical examination room at the outpatient department, this being the point of entry for all survivors of SV presenting at the intervention site. In order to ensure that evidence collection was undertaken during the medical examination, the examining medical doctor was mandated with the responsibility of using the rape kit to collect all the relevant samples, as per the complaint presented by the survivors.

The collected samples were then transferred by a nurse to the laboratory for further analysis. This was done so as to reduce the possibility of sample contamination by the survivors or their guardians, and to eliminate the need for survivors to queue at the laboratory for the investigations to be done. At the comparison site, the standard procedure was for the survivors to go to the laboratory for their

blood to be drawn, urine bottles given to them; and swab collection sticks given to them to take to the examining doctor to obtain a high vaginal, anal or oral swab.

Movement of the samples collected using rape kit



At the intervention site, key informant interviews were conducted with 5 HCWs providers, namely a Medical Doctor, a Clinical Officer, a Laboratory Officer and a Nurse Offices in Charge of the outpatient department where the rape kit was located.. The interviews explored the procedure used in obtaining samples from survivors, movement of the samples to the laboratory for analysis, and feedback of results back from the laboratory. Also interviewed were conducted with 2 police officers stationed at the gender desk. The interviews sought to establish the storage procedures of evidence handed over to the police by HCWs

One nurse at the OPD was assigned the responsibility of monitoring the use of the rape kit by carrying out a spot check on numbers of survivors attended to against number of rape kits or components used. This exercise brought to fore the need for the rape kit and the components therein to be serialised for ease of tracking. It was also established that there was no need for the kit to have needles and syringes as these came as pre-packed together with the Vercutainer tubes.



Respondent: *"..Some things in here {in the rape kit} we don't use for all everybody {all survivors}. For example a child or a child will not need to use something like this one {speculum}, because it is a bit big. So if you find a small one, although they are rarely used, sometimes they are useful. If it is a child, maybe they can use maybe a swab stick or something depending with the injuries"*

Nurse, Intervention site

"... I think there are just so many things that we do not need. I think there is one here; I think I have some of them {rape kits} here. You see like now this is one which has been used, and look what is remaining there. This is another one. That is now what happens. All these are kits which have already been used. But you see again and I think this is important, you've got to know that at times rape cases are not all the same, there is always a difference of this case may need this many{rape kit components} while this one may not need. Because for example if you get a case like this when you know there is penetration and maybe you get all the victims plus the perpetrator, and the perpetrator is somehow agreeing on this. With that one maybe for example you may need to do to use only 2 swabs and not all, one for laboratory and one for the DNA. The others now become wasted. And you know they are actually, I think there are 5 in this kit."

Medical Doctor, Intervention Site

The interviews revealed the absence of a paper trail for the rape kit from the point of issuance at the facility to the point of use within the examination room. This, health care providers indicated, could be addressed by developing a labelling system for the kit using varied envelopes.

The nurse in charge of the rape kit was, overall, satisfied with how survivors were being attended to since the introduction of the kit. Improvements in evidence collection were attributed to the introduction of the rape kit.

"It is user friendly because it contains almost everything such that you will not lose anything when you are obtaining samples from a survivor. We will first of all finish with this one {one kit} and then get another one. So it is user friendly because it has almost everything"

Nurse, Intervention Site

".. The biggest problem in hospitals is that the supply of some of these things {commodities required to retrieve evidence} is not sufficient. As much as they would want to have these things there, that is where the problem is. There is no point of keeping a client here maybe for 2-3 hours, waiting for a small thing like this {swab} to be sterilised. And that time somebody is telling you we don't have cotton wool. I mean it just doesn't make sense. That's why me I find this {rape kit} so convenient. Because I know the many times there is a rape case here I know in the next at most half an hour, I will be through with that client, the client will be happy, yeah, and that kind of thing"

Medical Doctor, Intervention Site

The collection of evidence at the OPD by one health provider was seen to reduce trauma on survivor as they did not have to repeat their complaints and/or occurrences of their encounter to different providers.

However the respondents indicated that some of the components of the rape kit were rarely used, leading to them having packs not 100% utilised. The commonly used items were 2 swab sticks, urine bottles, vercutainer tubes, gloves, 2 envelopes for clothes and inner wear, and speculum(for adult female survivors). The feedback obtained from the respondents informed the review of the rape kit with an aim of providing the HCWs at the intervention site with printed and labelled envelopes instead of having to procure labels separately. It was also noted that none of the HCWs used the tape measure to document extent of injuries presented by the survivors and there was no need to have needles and syringes in the kit as the Vercutainer kits were sufficiently equipped to help in the drawing of blood. It was also recommended that the rape kit components be sealed in a non-polythene bag as this would help guarantee the security of the individual components that are sterilised.

2. Handling of evidence by the police

Interviews with the police showed that at baseline, they did not have the required envelopes to aid in packing evidence collected.

Respondent: *what we need help with is equipment. Like for example you see these clothes that I have here. They were brought in that paper bag, and you can't bring them in the paper bag. if you want a place {envelop} to pack them then you have to buy it yourself. Because you cannot go and tell the survivor to buy. That would be offending them. Because you want for them to help you and you also help them. So don't show them that you do not have the envelope. You just have to buy it yourself, so that it reaches {the government chemist} when it is okay.*

During the intervention, printed envelopes similar to those used by the hospital were availed to the police to aid in packaging of evidence. However, during the in-depth interviews and site visit by the study team, the police indicated that lack of storage facilities at the station, and delayed receipt of feedback from the government chemist as a challenge.

Interviewer: *So when you send this to the government chemist, how long does it take before you receive the results?*

Respondent: *There is one that I sent {to the Government Chemist}. But let's just say that it takes a very long time. There is one is sent in August, and it has not been returned until now {November}. I have been sending people there, using my own transport. Even when I was taking those samples, I used my own money to pay the transport for an officer to take it there. When the hearing of the case was nearing, then you ask for the results, you know they may think that you are delaying because you are the one who failed. But you want to strive so that your case can succeed. But until now, I have not got them.*

Police Officer, Intervention site

The feedback received from the police indicated that close proximity of the police stations to the government chemist does not necessarily result in timely delivery of exhibits for further analysis to the government chemist. Mechanisms are required to address storage and transportation of evidence gaps faced by the police; and specimen analysis delays at the government chemist. (as shown below).

An illustration on handling of evidence at one of the police stations



Figure 1:
Police station

Figure 2:
Entry of evidence
into police records



Figure 3:
Verification of exhibits



Figure 4:
Poor packaging
and labelling of
exhibits



Figure 5:
Lack of secure storage
facilities



Finally, findings from the key informant interviews indicate that the utilisation of the rape kit in evidence collection and national documentation protocols was found to be largely informed by:

- a) Knowledge levels amongst service providers on how to use the P3 and PRC form
- b) Retention of staff trained on utilisation of the rape kit and medico-legal documentation

D. Documentation Procedures

1. Proportion of cases with required documentation

At baseline, it was established that the main documents used in recording the management of survivors of SV were the PRC form, registers, P3 form and the occurrence book. In both the health facilities, all these documents were stationed at different service delivery points within the hospital and/or police station. For example, the PRC form was found at both the outpatient department and the comprehensive care clinic; hence, it was difficult to have it duly filled in by the examining doctor. On the other hand, the PRC register which should be filled in by the examining doctor was located at the trauma counsellors' room in both health facilities.

The national guidelines on the management of SV, revised in 2011, allow for the PRC form to be filled in by a doctor, clinical officer, or a nurse. Previously, only doctors could complete this form. This form is also to be utilised as health providers' notes on the type of management that was accorded to the survivor. It is also stipulated in the guidelines that for each survivor, the Kenya Police Medical Examination (P3) form should be filled. The PRC form is then to be attached to the P3 form.

This was found not to be the practice at baseline, as either no PRC form had been filled in for survivors, or the filled in forms were not availed to the study team, as highlighted in Table 11 below. In the intervention site, health care workers made efforts to use the required medico-legal documentation as per the baseline data. At the comparison site, it was established that the health care providers either did not fill in both of these documents for the survivors, or they did not properly store these forms.

At end line, there was considerable improvement in the extent to which health care providers at the intervention site were using the PRC form. There was a significant difference between the intervention and comparison sites in completion of PRC forms (Chi square 16.45, $p = 0.000$; 95%CI), while for P3 forms, there was no significant difference. This was so because in both health facilities, it is the Medical Superintendent who was required, by the hospital administration to fill in the P3 forms, in readiness for appearance in court as expert witnesses, hence the few P3 forms that were filled in as compared to the PRC form. So while, the number of health care providers utilising the PRC forms for documentation increased as shown in Table 11, not all cases had P3 forms filled in.

Table 11: Documentation of Survivors at different service delivery points

Source documents	Intervention site		Comparison site	
	Baseline	End line	Baseline	End line
Trauma Registers	42	56	13	32
P3 forms	26	48	14	25
PRC forms	0	79	10	42
Laboratory	89	179	26	67
Pharmacy	0	0	10	48
Total	157	362	73	214

In the comparison and intervention sites, the laboratory register was the main document used in PRC management. It was not possible for the research team to capture data from the pharmacy registers at the intervention site, as this register for the entire hospital was computerised with no specific codes assigned to survivors of sexual violence.

The national guidelines on the management of sexual violence stipulate that information about survivors should be recorded in four key documents, namely, the laboratory, trauma, P3 and PRC records. A review was undertaken to determine the extent to which the survivor details were filled in the different national documents used in health facilities for documentation of PRC services provided (Table 12). The analysis below focussed on survivors whose details were captured in more than one document.

At baseline, the intervention site mainly used two documents (the laboratory register and the trauma

Table 12: Survivors as Traced in Different Health Facility Records

Source documents at various service delivery points	Intervention site		Comparison site	
	Baseline	End line	Baseline	End line
Laboratory,Trauma,P3,PRC	0	14	2	3
Laboratory,Trauma,P3	8	3	1	1
Laboratory,P3,PRC	0	10	0	0
Laboratory, Trauma, PRC	0	8	3	12
Trauma,P3,PRC	0	1	0	5
Laboratory, Trauma	23	11	1	1
Laboratory,P3	7	13	0	0
Laboratory, PRC	0	24	0	5
Trauma,P3	0	6	0	0

register) to capture the details of SV survivors, while the comparison site used mostly three documents (laboratory register, trauma register and PRC form). This situation changed by the end line period, as providers at the intervention site were trained on the importance of using the PRC form, in addition to the DRH disseminating the revised PRC forms in health facilities providing these services. This resulted in more health care providers utilising the four documents at the intervention site. The reduction in number of survivors recorded in the trauma register at end line in the intervention site was informed by the weakened referral of survivors for counselling, due to the unavailability of a designated service provider.

However, out of 313 SV survivors attended to in the intervention site, 130 (42%) had their details recorded in more than one of the key national documents. While health care providers at the intervention site were more likely to utilise the four key documents, than those in the comparison site, the analysis revealed that both the sites improved in filling in the four documents. At end line, 14(11%) of the survivors in the intervention site had their information recorded in the four key documents, compared to 3(11%) in the comparison site. This increase could be attributed to the training carried out at the intervention site, go ahead given by the medical superintendent for nurses and clinical officers to fill in the PRC forms in accordance with the national guidelines and the dissemination of the revised PRC form to health facilities by the DRH and LVCT.

In the comparison site, the laboratory and trauma registers and the PRC form seemed to be the preferred documents at baseline and by end line. This is an indication that many SV survivors go to the laboratories and for evidence collection, but may not go to the other service delivery points. This is the loss in the chain of documentation that this study sought to address by having all evidence collected at the OPD in the intervention site, while in the comparison site the survivor still had to go to various service deliver points for evidence collection.

The above findings highlight the need for laboratory personnel to have their capacities built on referring the survivors back to the OPD and counsellors for comprehensive management once evidence is analysed, given the importance of their role in documentation, and that in both intervention and comparison site hospitals, it was mandatory for all evidence to be taken to the laboratory for analysis. There is need for health facilities to put in place mechanisms that will facilitate evidence retrieval to be done at the first point of entry so as enhance comprehensive collection, documentation of samples before they are transferred to the laboratory for analysis. This will greatly aid in enhancing the chain of custody of evidence.

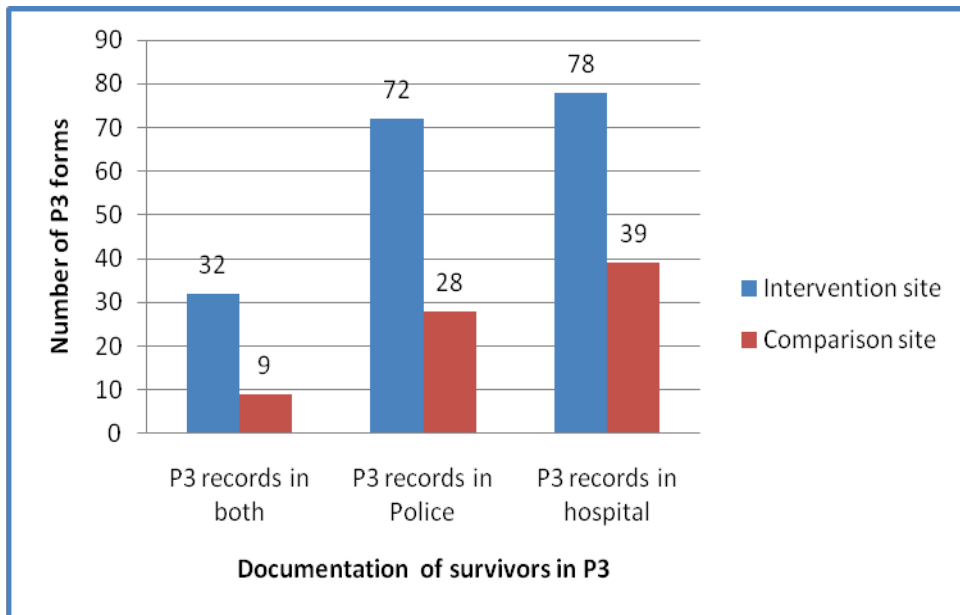
At the intervention site, there was reduction in the number of survivors who received trauma counselling at end line. This was attributed to lack of designated staff to offer and document trauma counselling services provided. The study noticed that emphasis was not given to trauma counselling services as the nurse whose day to day responsibility entailed provision of trauma counselling services was promoted and assigned managerial duties during the intervention, and no replacement was made to ensure survivors accessed counselling services

It was also observed that the limited use of the trauma counselling form in both health facilities could be attributed the HCWs utilising manually prepared books as trauma counselling registers mas the national trauma form had not been disseminate by the Division of Reproductive Health to health facilities. As such in certain occasions the HCWs did not make an effort to standardise the variables drawn up in the trauma counselling register.

2. Completion of PRC and P3 forms

The study aimed at testing the feasibility of using a locally assembled rape kit as a strategy for ensuring that the PRC and P3 forms are completed. Thus, completion of P3 forms at the police stations and at the health facilities were compared. At end line, the intervention site was more than three times as likely as the comparison site to have P3 forms completed at both the police station and health facility (Figure 1). The intervention site was also more likely than the comparison site to have filled out P3 forms filed either at the police station only at the hospital. It was also established that these forms were accurately filled in matching the details documented in the PRC forms.

Figure 1: P3 Forms traced at Health Facility



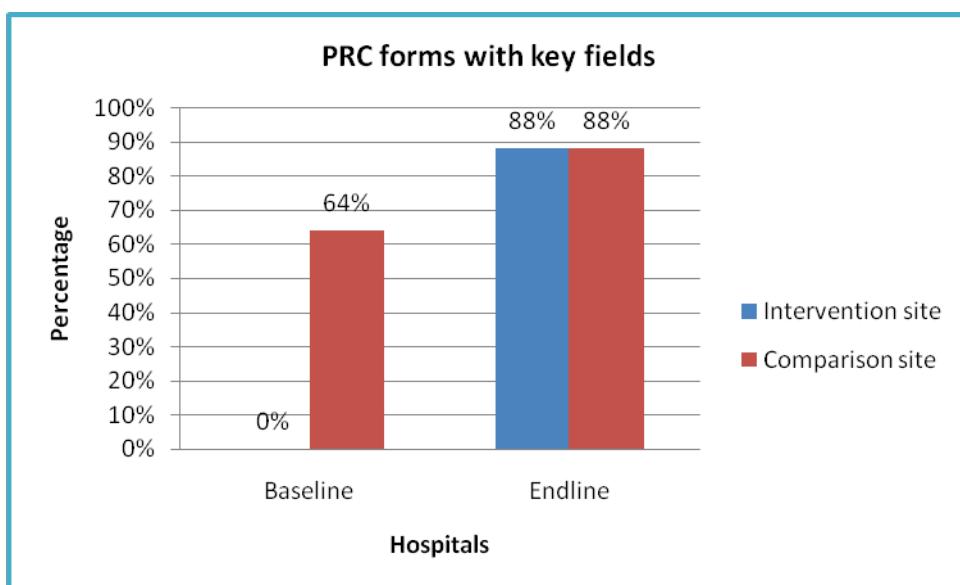
3. Proportion of PRC forms with key fields completed

During the baseline period, the data captured from the comparison site showed that 64% (173) of the SV survivor cases had the PRC forms accurately filled, while no survivor had a PRC form filled in for them at the intervention site.

During the intervention period, both intervention and comparison sites were supplied with the PRC forms, although only health care providers in the intervention site were sensitised on how to use the form.

At end line, the evaluation focused on establishing accurate utilisation of the PRC form in both sites by looking at the following key PRC form variables: *demographics of the SV survivors, date of assault, type of complaint presented, and type of evidence retrieved from survivors*. A PRC form was regarded as complete only if all these variables were filled in. The findings are presented in figure 2 below:

Figure 2: PRC forms with Key Fields Filled in



At the comparison site, the 64% completion of the PRC form could be attributed to training of service providers at this site during a previous LVCT study in 2008/9. The service providers at the intervention site were sensitised during this study. However, the hospital administration had issued a circular giving medical doctors the sole responsibility of filling in the PRC forms. The issued circular was informed by some malpractices observed in the hospital in handling a general caesarean operation that resulted in the Medical Superintendent limiting the examination of survivors and documentation using the PRC and P3 form to medical doctors only. This resulted in the research team not being able to trace any PRC forms during baseline as clinical officers who were attending to survivors indicated that they only filled in history obtained from the survivor in the patient note book and not the PRC forms, as per the circular issued by management.

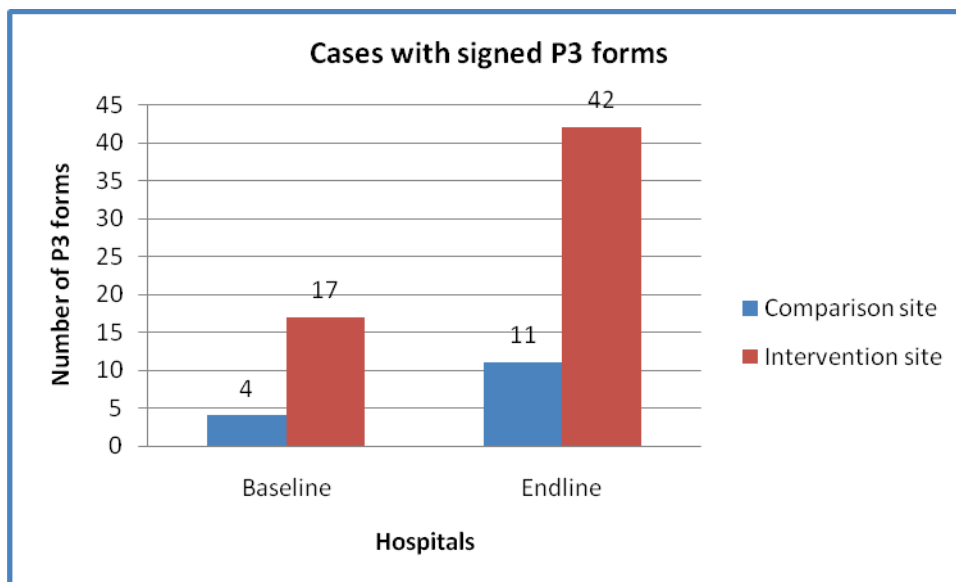
During the intervention, the LVCT PRC officers and the study PI held meetings with the hospital management and sensitised them on the revised PRC guidelines, which stipulate that the PRC form should be filled by the examining doctor, clinical officer, or nurse. Consequently, the nurses and clinical officers were permitted to fill in the forms as per the national guidelines. As a result, there was an improvement (88%) in the level of utilisation of the PRC form of which 88.6% (70) had all the required variables filled in. In the comparison site, 7 (70%) of the PRC forms were filled in at baseline. At end line, the proportion of PRC forms with complete variables increased to 88% out of the 42 filled.

The figure above shows that the comparison site also recorded a slight (but comparatively much lower) improvement in the level of utilisation of the PRC form. This change could be attributed to the continued mentorship of all LVCT staff attached to support PRC services in health facilities.

4. Number of cases with signed P3 forms on file

A signed P3 form by the police officers and examining doctors acts as evidence that can be used in prosecuting an assault case. For this reason, the study sought to find out the proportion of cases with signed P3 forms among the cases recorded in the two hospitals. There were 331 and 170 SV cases recorded in the intervention site and comparison site, respectively.

Figure 3: Number of Signed P3 forms



Of the total number of SV cases recorded at the two districts (501), only 15% (74) of the cases had signed P3 forms at the hospitals as shown in Figure 3. In the intervention site, 23% (n=74) of the cases before the intervention had P3 forms as compared to 57% after the intervention. In the comparison site, 5% and 15% had P3 forms at baseline and end line, respectively. Between the intervention and comparison site police stations, there was no significant difference in the way these vital documents were handled (signed).

This could be attributed also in the drop out of cases reported at the police station due to out of court settlements

Interviewer: *How many survivors of SV have you seen since the training?*

Respondent: *Let us just say, if we count, they could be 20*

Interviewer: *Out of those 20, have you referred them all to the facility*

Respondent: *There are those who we tend to, like for instance, there are many who have let us down. Someone comes and reports and after they have reported and you now want to follow up the case and take them to court, they say no, this is my husband I cannot take him to court. I just want the police to speak to him and for him to listen. Because the chief spoke to him and he did not listen. So I just want the police to speak to him, they reach an understanding, and then we go our way. So those who get to court are few, not many.*

Police Officer, Intervention Site

SUMMARY OF KEY LEARNING POINTS AND RECOMMENDATIONS

Enhanced collection of medico-legal evidence

The collection of evidence at the OPD by one examining clinician can contribute to reduction of trauma to the survivor by having evidence collected by more than one service provider at various service delivery points. This could also increase survivors' confidence that their information will remain confidential, since they do not have to tell of their ordeal to more than one person.

The introduction of the rape kit at the outpatient department was perceived by providers to have resulted in a reduction in the amount of time taken by clinicians to assemble required equipment before collecting evidence.

The utilisation of the rape kit at the OPD improved the chain of custody, as evidence collected was transferred to the laboratory for analysis by a health care provider or support staff as opposed to the comparison site where survivors or their relatives were entrusted with this responsibility, potentially compromising the quality of evidence collected.

However, there is need for serializing the different components of the rape kit to avoid wastage of components depending on the evidence collected per case. In order to reduce delays in evidence collection at the health facility due to staff shortages and long patient queues, there is need for evidence collection and documentation to be centralized within a specific room within the health facility equipped with the rape kit, PRC and P3 forms, and prophylactic treatment.

Improved documentation of medico-legal evidence

The study revealed that availability of trained staff on its own does not necessarily contribute to proper evidence management. In addition to the training of service providers, there is need for the government to widely disseminate all the national documentation protocols, including gazetting the use of the PRC forms by the doctors, nurses and clinical officers.

Training of service providers from different government departments on the existing national documents for use in the management of cases reported or for referral of survivors from one institution to the next can greatly contribute to the utilisation of these documents. Both sectoral and joint multi-sectoral on the job trainings should be considered for this purpose.

Inclusion of health facility based evidence as medico-legal evidence at the police station

The study established that the P3 and PRC forms play a key role as documentary evidence, hence the need for all service providers to be trained on the importance of using these standard forms to document details of the complaints presented by survivor, type of evidence collected; referrals given, and identifying information of the service providers involved.

With the exception of the laboratory personnel, many service delivery points within the hospitals and police station continue to experience situations where survivor's details do not get documented using national protocols. This could be attributed to high staff turnover of staff trained on PRC management and to the lack of modules within the pre-service training curricular to equip health and law enforcement personnel on the standard management of survivors of violence.

Scalability of the intervention across different health facilities and police stations

The findings of this study suggest that it is feasible to have public health facilities utilise a pre-packed kit to facilitate evidence collection by the examining clinician during history taking. This is so given

that the rape kit was assembled using equipment that can be easily procured through the government supply chain.

However, in many instances, health care providers and the police mismanaged certain forms of evidence for lack of well-equipped storage facilities. This also applies to the evidence collection requirement of having specimens collected in sets of three, one for immediate analysis, one for transfer to the Government chemist for further analysis; and the last one for future reference should the survivor not wish to take legal action immediately.

Both the intervention and comparison site did not have adequate facilities for storage of evidence or documentation maintained for survivors of SV. This situation could also be assumed to be true in all public health facilities. There is therefore a need for the Government of Kenya to put in place mechanisms that would enable service providers to store evidence obtained from survivors in a secure and safe manner until mention of cases in court.

Lessons learnt:

1. High staff turnover at health facilities remains an impediment in delivery of quality care and documentation. Whilst on the job training should continue, this also makes pre-service training of all providers and imperative.
2. Lack of proper and adequate storage facilities is an impediment to preservation of forensic evidence by police and health care providers.
3. Capacity-building for service providers on how to manage cases of delayed presentation requires urgent attention. In some instances, HCWs have resorted to administering PEP and EC to survivors who presented past the 72 hours (for PEP) and past 120 hours (for EC).

Recommendations:

1. Scaling of utilisation of the rape kit can best be achieved through the development of national standard operating procedures to govern delivery of PRC services across all public health facilities in a timely and efficient manner.
2. Whilst the rape kit components are locally available, there is need for a quality assurance and control mechanism to be put in place to safeguard its use and results obtained. This will go a long way in promoting not only collection of evidence to confirm an assault occurred but also forensic evidence to link the survivors and perpetrator to the crime scene.
3. There is need for pre-service training institutions for health, and law and order to have modules on post rape care management to help reduce the costs involved in training staff in-service. This will also help minimise the effects of staff turnover on quality service delivery.
4. There is need for the relevant government departments involved in management of survivors to develop standard protocols on the type of evidence to be collected from survivors who present for PRC services after 72 hours.
5. There is need for further research on level of referrals of survivors and evidence across different sectors in an effort to inform the development of national referral protocols.

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ANNEXES

ANNEX 1: POST RAPE CARE FORM

Day		Month		Year				Province Code	District Code			OP / IP No.				
Last Name								First Name	Date of birth	Date		Month		Year		Male
Contacts (Physical Address and Phone number)																
Date and time of Examination								Date and Time of Assault				No. of Assailants				
Alleged Assailants (Indicate relation to victim)								Unknown				Known				
Place Assault Occurred																
Chief complaints / Presenting Symptoms																
Circumstances surrounding the incident (survivor account) remember to record penetration (how, where, what was used? Presence of struggle?)																
Type pf Assault				Use of condom?		Incident already reported to police?										
Oral				Yes		Yes (indicate which station and when)										
Vaginal				No		No										
Anal				Attended a health facility before this one?				Where you treated?				Were you given any notes?				
Other sex				No				Yes				Yes				
				Yes (indicate which one and when)				No				No				
Comments																
Significant medical and/or surgical history																
OBS /GYN History				Parity	Contraception type		LMP		Known Pregnancy?		Date of last consensual sexual intercourse					
									Yes	No						
General Condition				BP	Pulse Rate		RR		Temp	Demeanor /Level of anxiety (calm or not)						
Psychological Assessment (Should be done by: -Psychiatrists, Medical Doctors, Psychologists, Psychiatry-trained nurses, Psychiatry social workers or Counseling psychologists of repute)																
P S		PREMORBID HISTORY (state the mental condition of survivor prior to assault)														

Mental Status Evaluation (*Tick as appropriate*)

- ☐ **Appearance** (kempt, unkempt, other)(specify) _____
- _____
- ☐ **Behavior** (appropriate, restless, calm, absent mindedness, other) (specify) _____
- _____
- ☐ **Mood** (low, excited, depressed, tense, irritable, tearful, anxious, angry, other) _____
- _____
- ☐ **Speech** (flow, tone, amount (specify) _____
- _____
- ☐ **Perception** (hallucinations, illusions, de-realization, depersonalization, dissociation, other) (specify) _____
- (specify) _____
- ☐ **Thought** (Preoccupation, Stream of thought, suicidal thoughts, helplessness, hopelessness, worthlessness, odd beliefs, flashbacks, specific fears e.g.. of open places, enclosed spaces, men, women, adults, strangers, other) (specify) _____
- _____

Diminished capacity to enjoy life _____

- ☐ **Cognitive Disturbance** (Orientation in time, place, person, level of attention, concentration (use serial seven subtractions)

Memory: short term _____, long term _____

Judgement _____

Insight – does the survivor understand what happened to her/him, possible consequences, any legal implications, any wishes of the survivor? _____

Diagnosis:

FOR CHILD SURVIVORS:

Evaluate behavior, mood and speech as above but use the following to evaluate thought:-

- ☐ **Drawing** – allow child to draw (e.g..) family members and let her/him comment on the drawing. report verbatim

- ☐ **Play** – by use of toys and dolls allow child to give comments on the play and report verbatim.

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

- Wishes (let child state her/his wishes)

Diagnosis

Forensic

Did the survivor change clothes?		State of clothes (stains, tears, colour, etc)			
Yes	No				
Were the clothes put in a non-plastic paper bag?		Were the clothes given to the police?		Did the police sign the rape register at the health facility?	
Yes	No	Yes	No	Yes	No

Did the survivor have a bath?		Did the survivor go to the toilet?			
Yes	No	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

General Examination	Describe in detail the physical status Physical injuries (sign in the body map) Outer genitalia Vagina/hymen Anus Other significant orifices
----------------------------	---

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

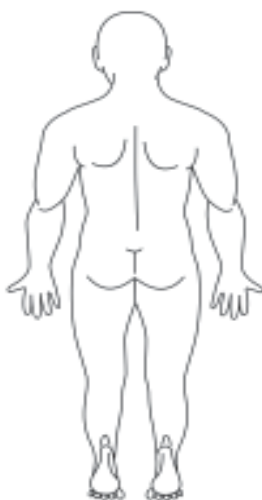
Please use the sketches below to indicate injuries, inflammations, marks on various body parts of the survivor

Sketch of person

Anterior view



Posterior view



Comments



Female Genitalia



Male Genitalia



Other Comments from the examination

Diagnosis/impression

					Stitching /surgical toilet done		STI treatment given	
	No	Yes	No	Yes	No	Yes	No	Yes

	no of tablets	which EC	Comment	Comment	
Any other treatment / Medication given /management?					
Referrals to	Police Station				
	VCT/DTC				
	Laboratory				
	OPD/CCC/HIV clinic				
	Trauma counselor?				
	Other (specify)				
Name of Examining Medical/clinical/Nursing Officer		Signature of Examining Medical/clinical/Nursing Officer		Date	
Laboratory Samples	Sample Type	Test	Please tick as is applicable		Comments
			National government Lab	Health Facility Lab	
	Genital - Anal - Skin - Oral swabs Specify	Sperm			
		DNA			
		Culture and sensitivity			
	High vaginal swab	Sperm			
	Urine	Pregnancy Test			
		Microscopy			
		Drugs and alcohol			
		Other			
	Blood	Haemoglobin			
		HIV Test			
		SGPT/GOT			
		VDRL			
		DNA			
	Pubic Hair	DNA			
	Nail clippings	DNA			
	Foreign bodies				
	Other (specify)				

Chain of custody			
These /All / Some of the samples packed and issued (please specify)			
To	Police Officer's Name	signature	Date
By	Medical/clinical/Nursing Officer's Name	signature	Date

ANNEX 2: P3 (POLICE) 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 injuries 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 _____

**SECTION "C"-TO BE COMPLETED IN ALLEGED SEXUAL OFFENCES
AFTER THE COMPLETION OF SECTIONS "A" AND "B"**

1. NATURE OF OFFENCE _____ Estimated age of person
examined _____

2. FEMALE COMPLAINANT

a) Describe in detail the physical state of and any injuries to genitalia with special reference to labia majora, labia minora, vagina, cervix and conclusion

b) Note presence of discharge, blood or venereal infection, from genitalia or on body externally

3. MALE COMPLAINANT

b) Describe in detail the physical state of and any injuries to genitalia

c) Describe in detail injuries to anus

d) Note presence of discharge around anus, or/ on thighs, etc.; whether recent or of long standing.

SECTION "D"

4. MALE ACCUSED OF ANY SEXUAL OFFENCE

a) Describe in detail the physical state of and any injuries to genitalia especially penis

b) Describe in detail any injuries around anus and whether recent or of long standing

5. Details of specimens or smears collected in examinations 2 ,3 or 4 of section "C" including pubic hairs and vaginal hairs

6. Any additional remarks by the doctor

Name & Signature of Medical Officer/Practitioner_____

Date_____

ANNEX 3: RECORDS REVIEW GUIDE



LVCT POST RAPE CARE MONITORING TOOL

A checklist for data capture

Health Facility/Police Station: _____ **Date Of Visit** _____

HCW/Police Talked to :

Name..... **Designation**.....

Hospital records:

The following information was collected from health facility records:

- ☐ Age and gender of survivor
- ☐ Complaint presented
- ☐ Evidence collected
- ☐ Services provided: medical, counselling and specimen analysis
- ☐ Documentation of complaint using PRC and P3 forms
- ☐ Number of survivors given PEP,& EC

Police records: data captured included:

- ☐ Type of SV cases reported (**Age, offence, p3 filled; OB number, sex, PRC filled; where the case is at**)
- ☐ Number of P3 forms returned from facility

ANNEX 4: IN-DEPTH INTERVIEW GUIDE FOR HEALTH CARE WORKERS:

- ☐ Primary information:
 - Designation: _____
 - Service delivery point: _____
 - Gender: _____
 - Trained on PRC: _____
 - When: _____
- ☐ How long have you been providing PRC services in this facility/service delivery point?
- ☐ What service do you offer at this service delivery point to survivors of sexual violence
- ☐ How many survivors have you attended to in the last one year
- ☐ Which of these do you carry out as part of your routine work with survivors of sexual violence:
 - Evidence collection: yes/No
 - Filling in the PRC form: Yes/No
 - Filling in the P3 form

(If they answer YES to any of the above, ask the questions below; and if they answer no to any of the above ask them to direct you to the service provider who undertakes these tasks for you to ask the following questions)

EVIDENCE COLLECTION:

- ☐ Kindly describe the type of evidence you collect from survivors of sexual violence
- ☐ What steps do you undertake in collecting these evidence
- ☐ What happens to the samples you collect
- ☐ What are some of the challenges you face in collecting these samples from survivors of sexual violence
- ☐ Do you hand over any of the samples collected to the police(YES/NO)
 - If yes: how do you hand over the samples to the police
 - Do the police sign on any document upon receipt of these samples
 - If No: What do you do with these samples
- ☐ How can the challenges you face in this facility in line with evidence collection be addressed?

DOCUMENTATION:

- ☐ Could you please mention the documents you use to records details of survivors attended to
 - ☐ Have you ever used:
 - A) the PRC form
 - If Yes: ☐ have you experienced any difficulty in using this form
 - ☐ are there any improvements you would like made on this form
 - ☐ How do the police get their copy of the PRC form?
 - If No(Ask them to direct you to the person who fills in the PRC form for you ask the above 2 questions
 - B)the P3 form
 - If Yes:
 - ☐ How do you get copies of the P3 form
 - ☐ How do the filled in P3 forms get handed over to the police?
- ☐ what are some of the challenges faced in documenting evidence

Additional questions for Kitui: health providers

- ☐ In your opinion was there any change in the services you provided to survivors of sexual violence after
 - The training on evidence collection and documentation
(Please describe this change)
 - The introduction of the rape kit
(Please describe)
 - Your engagement with the police
(Please describe)

ANNEX 5: TRAINING SCHEDULE

Training on Collection and Documentation of Evidence 3rd-5th August, 2011			
Date	Time	Activity	Responsible
Wednesday	8.00am-10.00 am	Registration	LVCT
3/8/2011		Introduction and objectives	
		Official opening - (Role of Hospital in Clinical Management/ referral mechanisms)	Med Sup
	10-10.30 am	Tea Break	
	10.30 am-12noon	DPP presentation 1	DPP
	12-1.00 pm	Evidence Vs Legal outcome(Case studies)	DPP
	1.00p.m-2.00pm	Lunch	
	2.00pm-3.00pm	Data management (PRC and P3 form)	LVCT
	3.00pm-4.30pm	Group discussions on legal hurdles faced by medics and Police officers-with focus on documentation	DPP
Thursday			
4/8/2011	8.00am-8.30am	Recap	LVCT
	8.30am-10.00am	Forensic evidence collection	Government Chemist
	10.00am-10.30am	Tea Break	
	10.30am-12.30 pm	Forensic evidence analysis and preservation...(rape kit and chain of custody)	Government Chemist
	12.30pm-1.00pm	Plenary discussion	LVCT
	1.00pm -2.00pm	Lunch	
	2.00pm-4.30pm	Police (Documentation; evidence management; evidence transportation to GC; referral mechanisms between hospital-police-govt chemist)	Police Facilitator
Friday			
5/8/2011	8.00am-8.30am	Recap	LVCT
	8.30am-10.00am	Police presentation(referral mechanisms between police-Hospital and government chemist)	Police Facilitator
	10.00am-10.30am	Tea Break	
	11.00am-1.00 pm	Chain of custody-using rape kit and documentation	Government Chemist
	1.00pm-2.00pm	Lunch	
	2.00pm-3.00 pm	Way forward	Med Sup and Police

ANNEX 6: DOCUMENTATION ALGORITHM

Algorithm for management of survivors of sexual violence



What is to be documented

Demographic information must include

- Official names of the survivor in FULL (as per the National ID or Birth certificate)
- Gender of survivor
- Age of survivor

Casualty /OPD

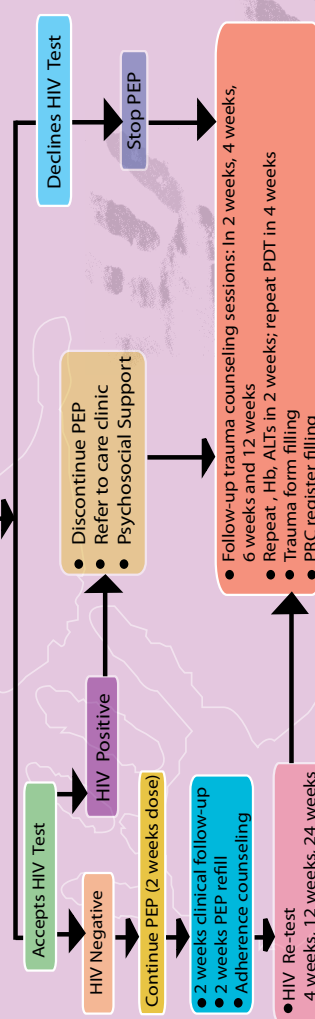
- Date of reporting to health facility
- Informed Consent
- Demographic information of the survivor including:
 - > Marital status
 - > Existence of any disability
- Details of the complaint:
 - > Presenting complaint
 - > Date and time of the sexual violation
 - > Details of perpetrators (Number: known or unknown)
 - > Type of sexual violation reported (as per SOA definitions)
- Head to toe examination undertaken
- Medical management provided
- Forensic samples obtained:
 - > Types of samples
 - > Whether survivor bathed or changed clothes
 - > Name and signature of examining health care provider
- Body injuries:
 - > Anterior and posterior view
 - > Genitalia/anal-rectal (male and female)
- Referrals made
- Chain of custody:
 - > Name and signature of health care provider handing over samples
 - > Name and signature of police officer receiving samples
 - > Date of the evidence transfer
- Documents to fill:
 - PRC form
 - P3 form
 - PRC register

Survivor presents within 72 hours (Treat this as an Emergency)

Any life threatening injuries should take priority over other aspects of Post Rape Care

Minimum Post Rape Care Package

History, Examination & Sample Collection • Obtain informed consent • Take history • Examine & Document injuries • Medical tests: HIV, PDT, Hb, HBV, HCV, CR, ALT, urinalysis and creatinine. • Collect forensic samples: HVS, oral/anal-rectal swabs, hairs, semen, blood stained clothes • Label, pack and store samples appropriately	HIV Prophylaxis • 1st PEP dose (3 days) (see details at the bottom)	Pregnancy Prevention • Levonorgestrel (postinor) 2 tabs 2 stat OR Eugynon OR Microgynon OR Nordette 8 tabs start (to women/girls of reproductive age)	STI Prevention • As per MOH guidelines	Hepatitis B Prevention • Hepatitis vaccine if indicated and available	Tetanus Prophylaxis • TT injection as per TT schedule	Counseling for: • Trauma • Pre and post HIV test • Adherence	Referrals to: • HIV Care clinic • Psychosocial support • Police and legal care • Shelters
---	--	--	---	--	--	---	---



HIV Prophylaxis

Children - Dosage is as per the Kg body weight

ABC + 3TC + LPVr for 28 days
Check ART guidelines or paediatric dosing wheel

Adult

TDF 300mg + 3TC 300mg Once a day +LPVr 500mg twice daily for 28 days
OR
AZT 300mg +3TC 150mg + LPVr 500mg twice daily for 28 days.

What is to be documented

Laboratory

- Demographic information of survivors
- Type of samples retrieved for:
 - > Medical or Forensic
- Tests undertaken:
 - > Indicate results of each test
- Documents to fill:
 - Lab request form
 - Customised lab register
 - Serology, Haematology & Urinalysis register

Counselling

- Demographic information of survivors
- Presenting complaint (as per SOA definitions)
- Emergency prophylactic treatment given
- Number of counselling sessions held
- Scheduled follow-up counselling visits
- HIV related counselling provided
- Referrals made

Pharmacy

- Demographic information of survivors
- Medication given:
 - > Type
 - > Regimen
 - > Duration
- Documents to fill:
 - Pharmacy register
 - STI register

National Guidelines on Management of Sexual Violence in Kenya 2009, recommends that all aspects of the survivor consultation are documented

References: National Guidelines on Management of Sexual Violence in Kenya 2009 and Guidelines for Antiretroviral Therapy in Kenya 4th Edition 2011



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