"HOSPITALS PREPAREDNESS TO PROVIDE COMPREHENSIVE CARE FOR GENDER BASED VIOLENCE SURVIVORS IN KENYA"

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DECLARATION

I Dr. Jane Wakahe do hereby declare that this Dissertation is my original Work and has not been presented to any institution for the purpose of obtaining a degree.

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TABLE OF CONTENTS

DECLARATION ii

APPROVAL iii

ACKNOWLEDGEMENTS v

DEDICATION vi

TABLE OF CONTENTS vii

LIST OF FIGURES x

LIST OF TABLES x

LIST OF ABBREVIATIONS xi

ABSTRACT xii

1.0 INTRODUCTION 1

1.1 Definition of Gender Based Violence 1

1.2 Epidemiology of Gender Based Violence 2

1.3 Special Groups 3

1.3.1 Child Sexual Abuse 3
1.3.2 Male Survivors 4

1.4 Management and prevention of GBV 4
1.4.1 Thuthuzela Centers 5

2.0 LITERATURE REVIEW 6

2.1 Female Genital Mutilation (FGM) 7

2.2 Domestic Violence 9

2.3 Sexual Violence 10

3.0 STATEMENT OF RESEARCH QUESTION 18

3.1 Research Problem 18
3.2 Research question 19
3.3 Study Justification 19
3.4 Study Objectives 19
4.0 METHODOLOGY 21
4.1 Study sites and participating institutions 21
4.2 Variables 23
4.3 Organization of Health Delivery Systems 23
4.3.1 Supervision of Health Services 23
4.3.2 Kenya Health institution Organisations 24
4.4. Study Unit 26
4.5 Sampling 26
4.6 Data Collection 27
4.7 Data Analysis 30
4.8 Minimization of errors and biases 31
4.9 Ethical Considerations and Consent 31
5 FINDINGS 32
Map of Kenya Showing Areas Visited 33
5.2 Registered Survivors 35
5.3 Meeting the Objectives 38
5.3.1 OPD Physical Facilities 38
5.3.2 Records 40
5.3.3 Staff 42
5.3.4.Psychological Support 45
5.3.5.Availability of Medicines 47
5.3.6. Laboratory back up and Forensic 49
5.3.7 Legal and Justice 52
5.3.8 Shelter and Outreach 53
5.3.9 Service Provider Attitude 54
Challenges-For Researcher 54
6 DISCUSSION 55

7 CONCLUSION 60

8 RECOMMENDATIONS 61

8.1 Institutional -Medical Officer in Charge of institution to ensure that: 61

8.2 Ministries and Government Departments: 61

REFERENCES 63

APPENDICES 66

A. Tools of data collection 66

B. Funding & Budget 77

C. List of Tables 79

D Communication Letters 84
Ethical clearance 84
Permission to Audit the Institutions 85
Permission to Visit Request 86

LIST OF FIGURES

Figure 1: Number of registered SV survivors in different cadres of institutions..... 35
Figure 2: Registered Survivors in institutions with and Without GBVRC (excluding the private hospital) 36
Figure 3: Registered Survivors in institutions with and Without GBVRC (including the private hospital) 37
Figure 4:OPD Closable doors 38
Figure 5: Availability of Counseling rooms 39
Figure 6: Counseling room privacy 39
Figure 7: Institutions completing PRC1 Forms 41
Figure 8: Proportion of Survivors to mandatory emergency staff 43
Figure 9: Proportions of survivors to staff in centers with and without GBVRC..... 44
Figure 10: Proportions of survivors to staff (Excluding the private hospital) 45
Figure 11: Proportion of SV/Counselor 46
Figure 12: Availability of Erythromycin Syrup 48
Figure 13: Availability of Erythromycin Tablets..... 48
Figure 14: Laboratory Back Up in different institutions. 50
Figure 15: Numbers of HVS or RS collected by different institutions..... 51
Figure 16: Proportion of institutions collecting HVS or RS 51

LIST OF TABLES

Table 1 : FACILITIES VISITED. 32
Table 2Registered Number of SV Survivors per Institution..... 79
Table 3: Mandatory Emergency Staff (Medical Officers, Clinical Officers, Gynaecologists and Lab Technologists) 79
Table 4: Proportion done HVS or RS 80
Table 5: Availability of Medicines 81
Table 6: Availability of Erythromycin..... 82
Table 7: Availability of counseling Rooms and Privacy 82
Table 8: Counseling Staff 83
Table 9: Completed PRC1 Forms 83

LIST OF ABBREVIATIONS

AMPATH	Academic Model Providing Access to Healthcare
ARTs	Anti Retroviral Therapy
CDC	Centre for Disease Control
EC	Emergency Contraception
FGM	Female Genital Mutilation
FIDA	Federation of Women Lawyers
GBV	Gender Based Violence
GBVRC	Gender Based Violence Recovery Centre
GTZ	German Development Cooperation
HVS	High Vaginal Swab
KNH	Kenyatta National Hospital
LFT	Liver Function Tests
MOH	Ministry of Health (Kenya)
MTRH	Moi Teaching and Referral Hospital
NGO	Non Governmental Organization
OPD	Out Patient Department
PEP	Post Exposure Prophylaxis
PGH	Provincial General Hospital
PRC1	Post Rape Case - Form 1
RS	Rectal Swab
STIs	Sexually Transmitted Infections
SV	Sexual Violence
WHO	World Health Organization

ABSTRACT

Sexual violence (SV) in all its forms is universal and occurs in every culture, and level of society in all nations and creed. In most cases survivors are women and girl children but men of various ages are also involved. Sexual violence is thus a global problem socially and spatially. affecting every population and all gender groups. In Kenya this problem is wide spread.

Health institutions have a major impact on the immediate and future health of the survivor. The first contact of a survivor at the health institution influences the physical, sexual, reproductive and psycho-social well being of the survivor and the reintegration into society. The ideal set up is to ensure that the survivor is comprehensively managed at the first health institution where they seek help and ensure efficient and immediate transfer to a better equipped unit when necessary.

The study was a baseline survey aimed at assessing the level of preparedness of Kenyan Health Institutions to comprehensively handle the ever increasing SV survivors especially during unexpected situations such as was seen during the 2007/2008 post election clashes. A sample of fourteen different levels of medical institutions as per the classification by the Ministry of Health of public medical institutions was audited. The audit was conducted between August and November 4th 2009. Data collected covered a six months period from March to August 2009. Of special interest was the composition of staff, physical facilities, laboratory support, availability of essential drugs and record keeping. Also noted was the negative attitude of the staff towards the enumerators and by extension towards the survivors.

The results revealed widespread lack of preparedness to provide comprehensive care for survivors of sexual violence. Inadequate or absence of infrastructure, inadequate or poor deployment of skilled staff, lack of essential drugs, unreliable laboratory back up and non-existent forensic material collection. The lack of communication among medical, legal and police arms was widespread at all levels of facilities.

Institutions that had integrated GBVRC services alongside the rest of the hospital activities registered more sexual violence survivors. This is positive in that the community is aware of the existence of such services. These GBVRCs are externally funded and this translated to more comprehensive care as was evident in one referral

hospital which was also the only institution with an Outreach program for survivors of Sexual violence.

In conclusion none of the audited Kenyan medical institutions are prepared to comprehensively handle survivors of sexual violence. One private hospital is uniquely situated by its reputation as the GBV centre and therefore handles many survivors of SV. One institution alone however cannot manage the whole country's GBV survivors.

The Kenya Government should prioritize gender based violence and integrate GBVRC's in all districts, provincial and national hospitals to comprehensively handle all its aspects. Improvement of infrastructure, laboratory and reliable supply of essential drugs should be addressed.

Specific training of all cadres of medical staff, the police and the legal arm of the government in handling gender based violence should be implemented in their curriculum and continuous education.

1.0 INTRODUCTION

1.1 Definition of Gender Based Violence

Gender based violence (GBV) may refer to any harm enacted against a person's will as result of power imbalances that exploit distinctions between males and females. GBV may be physical, sexual, psychological, economic, or socio-cultural and may be perpetrated in public or in private settings. While not exclusive to women and girls, GBV primarily affects them more extensively in all cultures. (WHO 2003)

Although GBV may affect both men and women, most times GBV is synonymous with violence against women and is defined as *'Violence that is directed against a woman because she is a woman or violence that affects women disproportionately.'* GBV can occur throughout a woman's life-cycle from early childhood to marriage and through married life to death.

GBV often goes unreported in many African communities since it is not even recognized as violence culturally. (Population Council 2006). It is even more difficult to get statistics of GBV against men and children. (WHO 2003)

Although any individual can be a victim of GBV, certain factors increase vulnerability particularly to Sexual Violence, these include:

Being female; unaccompanied female; female living alone; children in foster care; being physically or mentally handicapped; being in correctional institutions or detention; having a drug or alcohol problem; involvement in prostitution; being in a situation of war or armed conflict among others.(WHO 2003)

Some of the more common types of GBV include:

sexual abuse and exploitation; domestic violence; human trafficking; legal discrimination; forced impregnation and sterilization; forced marriage; forced prostitution; forced recruitment; harmful practices like genital mutilation; forced exposure to pornography; virginity tests.

1.2 Epidemiology of Gender Based Violence

GBV occurs in each and every community quite often, however the level and frequency of violence changes from region to region and across different cultures. Incidents of GBV are less frequent where women are more liberated and educated and are aware of their rights. In these same regions there are laid down procedures of dealing with GBV and when reported to the authorities the survivor is not subjected to guilt and self blame. This ideal state is however, rare and is only found in some developed countries. In most of Africa, South America and the Asian countries, GBV is rampant. Coincidentally, the regions where GBV is rampant frequently experience political upheavals and armed conflicts, during which time incidences of GBV increase markedly.

Gender Violence Recovery Centre records at the Nairobi Women's Hospital show that sexual violence is the commonest gender based violence reported accounting for over 80% of all these cases reporting to the hospital (Annual Report 2007-2008, 2005-2006). According to WHO, at least 24% of women have been raped at sometime in their life (WHO 2004). Prevalence of sexual violence is difficult to assess due to limited reliable statistics. According to WHO guidelines 2003, population based studies of abuse by intimate partners indicate that the prevalence of sexual violence (SV) is between 6% and 46% of the female population. There is significant underreporting of SV with varying reasons. Some may fear retribution, ridicule, lack of confidence in the health workers and investigators. Men are even more likely not to report being victims of SV and this makes statistics for men even less available. Statistics of SV on children suggest that 7-36% of girls and 3-29% of boys have undergone sexual violence. (WHO 2003)

This study sought to investigate hospital's preparedness to handle SV. According to WHO (2003) (80%) of all GBV is SV. Any hospital that can comprehensively manage SV will also be in a position to manage all other GBV-hence the choice of auditing-depth for SV to represent all GBV.

1.3 Special Groups

Child SV is now a global problem and WHO (2003) records that 7-36% of all girl child and 3-29% of boys suffer SV. Globally 40 million children are defiled annually. Another special group is the adult men who are sexually violated.

1.3.1 Child Sexual Abuse

Gender based violence and particularly sexual violence has grave consequences on the survivor, both immediate and long term irrespective of their age or gender. The situation is even more severe among children since most of the time the perpetrator is someone known to the child and probably a person the child trusts.

As formulated by the 1999 WHO Consultation on Child Abuse Prevention;

"*Child Sexual Abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws and taboos of the society. Child sexual abuse is evidenced by the activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:*

- *inducement or coercion of a child to engage in any unlawful sexual activity;*
- *exploitative use of a child in prostitution or other unlawful sexual practices;*
- *Exploitative use of children in pornographic performance an materials".*

Unlike the adult survivor, physical force is rarely used among children. Instead the perpetrator who is usually known and trusted caregiver tries to manipulate the child's trust and hide the abuse. There are normally repeated episodes of abuse which become more invasive over a period of time. Thirty three (33%) of all child sexual abuse is intra-familial. (WHO 2003)

WHO estimates indicate that 40 million children are either physically or sexually abused annually (WHO 2001). Myths that sex with young virgins can cleanse the perpetrator of HIV virus has contributed to the phenomenon of child rape in Africa.

To elicit proper history of defilement and to be able to collect the relevant forensic material from children the staff needs special training. Specialists therefore in handling children should be available. Children rarely disclose abuse and when they do it is

usually a process rather than a single episode. Follow up is of great importance to assess the social and psychological support of the child and family. The child may present with severe physical injuries and need to be examined under anesthesia. Where STI is prevalent, prophylaxis against them with the child specific dose levels should be administered. To reduce delays, paediatric protocols state that HIV testing need not precede PEP provision.

1.3.2 Male Survivors

Men and women can be either survivors or perpetrators. A significant number of males and especially boys are survivors of sexual violence. In 2007 the Nairobi Women's Hospital reported that 7% of survivors received in the institution were males. World wide, 5-10% of reported cases of sexual assault are males. (Youth Resource Library) Due to stigma and prejudice regarding male sexuality and masculinity, men are less likely to seek medical care, legal or psychosocial support for SV.

The male survivor is likely to be more concerned about their masculinity and stigma associated with powerlessness. Male survivors of SV therefore need even more intense and specialized counselling in GBV matters.

1.4 Management and prevention of GBV

The ideal approach to management of GBV and prevention of GBV is multi-sectoral and multi-disciplinary. To comprehensively manage this problem, Population Council (2006) recommends the following as essential requirements;

- Medical management of sexual violence at point of first contact with the survivor.
- Psychological counseling of survivors at the same reporting point.
- Sensitive approach to manage child survivors of both sexes and encouraging and enabling presentation of male survivors.
- They also recommended collection of forensic material and establishment of chain custody of evidence that can be used during prosecution.
- Strong links between police and health facilities to enable incidents to be reported in either direction to lead to possible prosecution where necessary.
- Introduce new or strengthen existing community-based prevention strategies which would be directly linked to the nearest medical/police structures.

- Address GBV through messages of prevention at community level and screen for signs of GBV during routine health consultations especially in children.

The closest there is to the ideal are the South African One-Stop Center for GBV developed mainly as prevention centers for HIV, known as Thuthuzela , a Xhosa word that stands for "Comfort or We Care".

1.4.1 Thuthuzela Centers

The word awakens feelings of warmth, security, and dignity to the survivor and gives them hope that something constructive will be done about their situation.
Thuthuzella Centers offer the ideal response to the problem and management of GBV in a region which has poor resources and gender bias. These centers have been introduced as a critical part of South Africa's anti-rape strategy aiming to reduce secondary victimization, improve conviction rates and reduce the cycle time for finalization of cases. They operate best in public hospitals and close to the area of the incident. These centers are linked to sexual offences courts which are staffed by skilled court staff and social workers.
Some of the services offered by Thuthuzella centers include:

- Transport to and from the center with a comfort person offering counselling en route
- An explanation of how the medical examination will be conducted and what clothing might be taken for evidence
- Consent form allowing the doctor to conduct the medical examination.
- Bath and shower facilities for the survivor
- An investigating officer to record the survivor's statement at the same venue
- Counseling facility
- Treatment for STI and PEP and emergency contraception
- Special consultations with the prosecutor and updates on the case and provision of safe shelter if necessary

2.0 LITERATURE REVIEW

GBV is universal. It occurs in every culture, at all levels of society, and in every country in the world. WHO Data indicates that at least one in every four women suffers GBV (WHO 2004). The vast majority of victims are women but men and children of both sexes also suffer GBV. Gender based violence is therefore global – geographically, culturally and also in terms of age and sex. Female Genital Mutilation (FGM) is among those cultural practices.

Population displacement subjects women to GBV. For instance refugee women and girls around the world are at the risk of being beaten, raped or even killed as they search for provisions and firewood for their families. Food distributed by relief agencies is raw and needs to be cooked, and as these women leave camp to fetch firewood, they fall victim to GBV. This has been reported in Sri Lanka, Ethiopia and Ecuador (Women's Commission 2008)

Health workers who come into contact with survivors of Gender Based Violence can help to recognize and influence the various aspects of recovery as well as collect and document evidence necessary for corroborating the circumstances of the violence. Health institutions need to have comprehensive gender sensitive services in order to cope with the mental and physical consequences of the survivors. There also is need to have a referral system to social welfare and legal aid or to better equipped facilities (Population Council 2008)

There are however gaps between the health care needs of the survivor and the existing level of health services in many countries. In most cases survivors are subjected to multiple examinations in surroundings that are unfriendly and without privacy. Most health institutions do not have a trained medico-legal examiner for those who present with GBV

In most instances there are not even the guidelines or proforma to be followed when examining such. Kenyan health workers are guided by the Ministry of Health guidelines on medical management of sexual violence which was published in year 2004.

It is because of these gaps that the World Health Organization (WHO) in the year 2001 embarked on developing guidelines to give direction and standardize world wide management of survivors of GBV. These guidelines became operational in year 2003.
An ideal situation as described in the WHO manual would include among others:

- Health care and legal forensic services would be provided at the same setting by the same person;
- All health workers should receive special training in providing services for survivors of GBV, including understanding of the local protocols, rules and laws applicable to GBV;
- Constructive and professional networking with other individuals involved in the care of the survivor e.g. social worker and police;
- Health workers must be trained to be free of bias and prejudices and maintain high ethical standards.

Resource constraints may preclude ideal provision of services but some minimum requirements must be met by all health facilities (WHO 2003). They must be accessible, secure, and clean and have privacy. The facility should be functional 24 hours even if only on call basis. Care should be ethical, compassionate, and objective and survivor centered.
There should be a sense of safety, security, and privacy. The sex of the health worker may be a problem and female nurses and doctors should be available whenever possible and there should be active effort to recruit female examiners. The prevailing situation is such that only a few facilities will have the ideal set up. In most facilities, the health component is offered at a different place and at different times from the medico-legal component and by different people.

2.1 Female Genital Mutilation (FGM)

One of the most cruel GBV is Female Genital Mutilation (FGM).This deeply rooted cultural practice is practiced in at least 28 African and Arab countries and immigrants

from those communities. (Richardson 2005) *Female Genital Mutilation comprises all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons.* WHO has classified FGM into four types:

Type I --- Partial or total removal of the clitoris and /or the prepuce (clitoridectomy);

Type II --- partial or total removal of the clitoris and the labia minora without excision of the labia majora;

Type III --- narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or labia majora with or without excision of the clitoris.(infibulation); and

Type IV --- all other harmful procedures to the female genitalia for non-medical purposes for example; pricking, piercing, incising, scrapping and cauterization

This same article (WHO 2008) records that FGM practice has negative health consequences, some immediate and some long term. Severe hemorrhage and urethral damage are two of the immediate complications. The amount of pain that the girl undergoes during and after is severe. The long term complications include; frequent urinary tract infections, chronic pelvic inflammation, inaccessible introitus for sexual intercourse and difficulties at child birth.

As a practicing gynaecologist, the author has performed several surgical interventions to make introitus penetrable for sexual intercourse. Personal conversation between Somali clients and the author reveals that a number of women who have undergone infibulation will undergo crude surgical separation of the labia either by the husband or some old woman to allow penetration during sexual intercourse immediately after marriage. For those who have already undergone FGM the hospital setting would surgically recreate the introitus in a more humane way under anesthesia. During childbirth, hospital with operation theatre facilities would be useful to offer caesarian delivery where the scar tissue would not stretch enough for a vaginal delivery.

Estimates show that between 100 million and 140 million in the world women have undergone FGM. Between 2 million and 3 million girls are at risk of undergoing the same

every year (WHO 2008) The ages at which this mutilation is performed varies from as young as 5 years to as old as 19 years. FGM may be performed at marriage and or during labour for a first delivery.

Health and Demographic Survey of Kenya 1998 showed 38% of women had undergone FGM. The Somali ethnic group in Kenya recorded the highest rate of up to 97%.The practice is supposed to protect virginity and family honour. According to Richardson (2005), many Muslims believe that FGM is an Islamic requirement.

2.2 Domestic Violence

Domestic violence is another form of Gender Based violence. *It is defined as abuse involving intimate partners in a family setting. It includes abuse of men to women and vice versa, and to children, women to women and men to men.(FIDA2002)* It occurs when a family member, a partner or ex-partner attempts to physically or psychologically dominate another. Although it refers to violence between spouses, domestic violence can also include cohabitants and non married intimate partners.

Domestic violence has many forms including physical, sexual, emotional, intimidation, economic deprivation and threats of violence. These attacks can be one sided (non-reciprocal) or involve counter attacks (reciprocal) Men can also be victims of domestic violence (London office 2005)

According to a study of Centers for Disease Control report quoted in Wikipedia, in year 2000, 7.5% men had been assaulted as compared to 25% women. Most (78%) violence towards children occurs at home. Forty to sixty percent of perpetrators of domestic violence also abuse children. Girls whose fathers batter their mothers are 6.5 times more likely to be sexually abused by their fathers than girls from non violent homes.

Many theories exist as to the causes of domestic violence. They include psychological that consider personality traits and mental characteristics of the offender. Social theories have also been advanced that consider external factors in the offender's environment.

such as family structure, stress and social learning. No single approach appears to cover all cases. Most abuses against women are due to poor resources. Many are dependent on the spouse for economic well being and societal acceptance. (FIDA 2002)
Having children makes it even the more difficult for women to leave abusive marriages due to the increased financial burden of supporting them. Dependency makes them have even fewer options and resources to let them make it on their own thereby giving them no option but to continue living in the abusive relationship. Violence sometimes arises out of a perceived need for power and control and is in actual fact a form of bullying. The perpetrator usually suffers from low esteem or feeling of inadequacy, unresolved childhood conflicts, the stress of poverty and hostility towards women or men among other causes. (WHO 2008)

Most perpetrators of domestic violence usually use alcohol and other drugs. (Hinga 2006) found that 85.3% of abusers fall into this category and that 62.6 % of these perpetrators had families with a history of violence, compared to 37.4% whose families reported no violence. Eighty four percent of the abusers were spouse while brothers in law accounted for 9.4%. (Hinga 2006)

Psychiatric morbidity was present in 53.3% of perpetrators of domestic violence. This study (Hinga 2006) recommended proper assessment to determine and treat psychiatric morbidity in the survivors. Another recommendation was to establish several centers nationally to cater for survivors both in hospital and non hospital settings. The study also recommended that survivors should have professional evaluation at the earliest possible time after the violence to determine and carry out possible interventions. As a preventative measure, creation of awareness of the various risk factors of domestic violence to the public should be enhanced.

2.3 Sexual Violence

Records from Gender Violence Recovery Centre based at the Nairobi Women's Hospital show that sexual violence is the commonest gender based violence reported in Kenya, accounting for over 80% of all these cases reporting to Nairobi Women's Hospital (Annual Report 2007-2008, 2005-2006)

World Health Organization defines rape as: *Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, acts to traffic a persons sexuality using coercion or threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting including but not limited to home and work.*

Rape includes acts such as: Forced penetration of the vagina or anus with a penis or other object, touching the private parts including the penis, vagina or anus oral sex (placing the mouth or tongue on a person's vagina, penis or anus.) or rubbing a penis, hand or other object against another person's private parts.

Prevalence of sexual violence is difficult to assess. There are very limited reliable statistics. According to WHO guidelines 2003, population based studies of abuse by intimate partners indicate that the prevalence of sexual violence (SV) is between 6% and 46% of the female population. There is significant underreporting of SV. The reasons for this vary. Some fear retribution, some fear ridicule and many have no confidence in the health workers and investigators. It is estimated that between them, rape and domestic violence account for the loss of 5-16 percent of healthy years of life in women of reproductive age (WHO 2003)

Causes and risk factors are social, economic and gender issues (Population Council 2008) This article affirms that there are society and community level risks such as; traditional norms that support male superiority; social norms that tolerate or justify violence against women; weak community sanctions against perpetrators; poverty and high levels of crime and conflict in the particular society.

Individual risk levels indicate violence is a learnt behaviour, for instance, boys who witness or experience violence as children are more likely to use violence against women as adults (Population Council 2008)

The article also records that SV is quite prevalent in Sub-Saharan Africa as shown below:

> In Kenya, 43% women of age 15-49 years reported having experienced some form of GBV in their lifetime; (29%) reported having experienced GBV in the year preceding the report; with 13% specifically on sexual abuse the previous year

In Zambia, DHS data indicate that (27%) of all married women reported having been beaten by their partner in the past year. The figure is even higher in the age group 20-24 years at 35%.

In South Africa, (10%) of age 15-19 years were forced or persuaded to have sex against their will.

In rural Ethiopia, (59%) of women have ever experienced sexual violence and (49%) of ever partnered women have experienced physical violence by the intimate partner.

In Rural Tanzania, (47%) of ever partnered women have ever experienced physical violence by an intimate partner while (31%) have experienced sexual violence

Men are even more likely not to report being victims of SV and this makes statistics for men even less available. Identification of sexual assaults committed against men is a recent phenomenon. According to Youth Resource Library, boys tend not to be taught to empathize. They are not taught the right to feel safe in their bodies and that the autonomy of their body is sacred. Little boys are not taught to say no to abusive clergy, scout masters, coaches, uncles, fathers and other potential perpetrators. Many males may not be able to define their experience as sexual assault. The main reasons that stop men reporting GBV and especially rape and domestic violence are extreme embarrassment and fear of ridicule. They also feel angry at not having been able to prevent it and they fear reprisal from the perpetrator.

In some settings like prison and armed forces SV against men may be more prevalent. Some of the more common SV on men are; Receptive anal intercourse, forced masturbation and receptive oral sex. The male survivor can be angry, confused blaming himself and desperately hurt. The hysteria and misinformation surrounding homosexuality makes understanding their assault very difficult. The article (Male on Male sexual violence) concludes that most survivors will never tell anyone that they have been assaulted.

Statistics of SV on children suggest that 7-36% of girls and 3-29% of boys have at some time undergone sexual violence (WHO 2003.) Sexual abuse in a child results in actual

harm to the child's health, survival, development or dignity in a relationship of responsibility, trust or power. A study in India in 1997 child rape accounted for 28.8% of all rape cases.(WHO Regional office South-East Asia) This article continues that in Thailand in 1998, every hospital reported sexual assault in under 10 years and also records the myth in South –East Asia that intercourse with a virgin may be a cure for STI. In South Africa, 40% of reported sexual assault cases are committed against children. (UNICEF 2008) Health service providers need to be alert to child abuse, understand the context of the abuse, identify signs and provide sensitive and empathetic care to child survivors.

According to Ministry of Health Kenya (MOH 2006) women have been socially and historically conditioned to depend on, please others, be passive, indecisive and self doubting. This social conditioning leaves women vulnerable to sexual violence and may affect their reaction as to whether or not they seek support after sexual abuse.

Fearing the displeasure and shame they may provoke in their families, many women decide to remain silent. (Bannon 2004) said gender based violence and especially rape exists in society before conflicts but that during uprisings because of the body politic, women become booty for soldiers.

In sub Saharan Africa, initiation of men and generational hierarchy teaches the belief that women are for the use of men, and this results in men asserting their masculinity over women. (Anderlini 2004) speaking about gender based violence in Middle East said that the subject is a taboo and violence against women is the norm.

If women gather courage to report, they are themselves accused of inciting the violence or of being immoral. (Ajema) in discussing some dominant practices in the communities in Kenya found that African Traditional Justice systems emphasize on reconciliation other than punishment of the offender.

There is no clear cut stereotype of a perpetrator of sexual violence. Suffice it to say that SV is an aggressive behavior. The usual reason for this act is for power and control, not

for craving for sex. It is a cruel act used to degrade, dominate, humiliate, terrorize and control women and children. The hostility, aggression and sadism displayed by the perpetrator are intended to threaten the victims and make them doubt their worth. Sexual violence violates the survivor's privacy, safety and well being.

Work with sexual offenders has confirmed that sexual desire is not the motivating factor. (WHO 2003) It is just a medium to express some emotions like anger against women and need to control and assert power over them. In the perpetrator, SV serves to compensate for feelings of helplessness, reassure the offender about his sexual adequacy, assert his identity, maintain his status among his peers defend against his sexual anxieties, get sexual gratification and discharge frustrations.

There is no stereotype of woman who gets raped or attracts a rapist. Any woman can be raped. Most rapes do not involve a lot of physical force. One gives in due to fear of serious injury or even death. A survivor of SV may then present with no physical injuries and may for this reason not be believed.

Some situations however make it easier for women to be raped. These include; Un-accompanied women, mentally retarded people, prisoners, drug or alcohol problem and states of war and conflict among many others. Perpetrators of SV come in all forms. They can be a date, an acquaintance, a friend, a family member, an intimate partner or even a total stranger.

More often than not though, it is a person known to the victim. These may even be people in authority who are trusted like a priest, a teacher or a doctor. Some sex offenders may use drugs to make it easier to control the victim without the use of much physical force and allow for date rape or even gang rape. By far the commonest drug used is alcohol. Others include; rohypnol, ketamine, cocaine, methamphetamine and marijuana among others (WHO 2003).

Whereas rape occurs throughout the years and under all situations, there are circumstances that favor the perpetration of the same. Breakdown of social and moral

order in armed conflicts puts especially women and girls in particularly vulnerable situation (Women's Commission 2006). Perpetrators include: other displaced members, members of other clans, members of other villages, other religions, ethnic, military and rebels, host population or family members.

Kenya experienced such a surge of rape incidences during the 2008 political insurgence. This was both urban and rural. Marked increase in rape was also experienced in the internally displaced person's camps. This was sometimes reported in the media how women in the camps had to exchange sex for food. Most of these cases went unreported. The question is whether the medical staff and medical institutions were and are well prepared to deal with the various aspects of rape. These include: physical trauma, sexual trauma and psychological trauma.

The extent and severity of trauma to survivors of rape in times of armed conflict is changing Rape is defined as a war crime under Article 8 (xxii) of the Rome Statute of International Criminal Court. Democratic Republic of Congo considers vaginal destruction as a war crime. As a result of internal conflicts there were increased gang rapes, use of guns, branches and broken bottles to violate women, girls and men. This resulted in vaginal fistulae (Women's Commission 2006)

A survey of survivors of rape in South Kivu region of DRC revealed 91% suffered from one or several rape related illnesses (Women's Commission 2006). The Burmese government has tried to violently suppress a local rebellion in Shah State since the 1990s by using rape as a weapon of war (Women's Commission 2006). Displaced Sudanese men and women continue to report abduction and widespread rape in Darfur.

In Kenya during the 2008 political clashes, British Broadcasting Corporation (BBC) reported that rapes had more than doubled and at least half of the victims were under 18 (Women's Commission 2008). According to the United Nations office for the coordination of humanitarian affairs, the reporting of rape markedly increased immediately during post-election violence.

In the first 2 days of the insurgence, 56 people were treated for rape and admitted in the Nairobi Women's Hospital alone. These women reported that many more had been victims but had not come forward to report. Rape survivors feel shame and disorientation and are not quite sure who they should report their problem to.

Many a time the first contact in a hospital may be male or even an unsympathetic female staff. This makes the survivor of rape feel like they are being violated all over again and they would rather not report the incidence.

In Kenya the annual report of Gender Violence Recovery Centre of April 2007 to March 2008 recorded that of the 2750 survivors of gender violence,2338 (85%) were sexual violence and of these more than 87% were female. with the majority of male survivors being children.

Rape is a problem of the society. How much help is sought and reporting is done by rape survivors depends on the particular society and culture. In the United States of America according to National Violence against Women Survey (NVAWS) 2007 there are 322320 cases of rape per year. Thirty six percent of these have physical injuries and require medical treatment.

Most sexual violence incidences will remain unreported due to shame, disgrace and for fear of being mistreated and not being believed. In the developed countries medical institutions have clearly laid out guidelines for efficient communication and referral pathways for sexual violence (Forbes 2007)

The Virginia protocol for treatment of SV survivors (2009) recommends a one stop point of treatment involving a multi-disciplinary team of health care providers, criminal justice professionals and sexual assault advocates. The health care facilities need to be patient centered and enhance forensic facilities. This Governor's commission found the commonest reactions of SV to be; loss of sense of safety and control; difficulty in processing information; inability to manage feelings; difficulty filtering internal and external stimuli and disruption of memory.

This is not the case in developing countries. (Changwa 2008) while assessing the quality of hospital care to SV survivors in a South Africa highlighted that there needed to be made available user friendly waiting and consulting rooms. The attitude of the health workers also needed improvement so they do not appear to disbelieve the survivors. (Jewkes 2005) in a situation analysis of rape services in South Africa in an effort to formulate Government policy found:

- Facilities lacked privacy, washing facilities and proper equipment
- That 70% of staff had no training to deal with SV
- That 33% of staff thought rape was not a serious concern or problem
- That only 35% named the proper drugs for prophylactic management of STI

The ministry of health Kenya in 2004 gave clear National Guidelines on medical management of rape (MOH 2007) Studies to determine the capacity of hospitals to implement these guidelines are needed.

3.0 STATEMENT OF RESEARCH QUESTION

3.1 Research Problem

Hospitals play a key role on immediate and long term wellbeing of SV survivors. It is of great importance to determine the capacity of Kenyan Health Facilities to comprehensively manage those who are either enlightened enough or courageous enough to request medical help. During times of riot and armed conflicts medical institutions are likely to experience more people with GBV seeking assistance.

Level 4 Kenyan health institutions (District Hospitals) serve a certain designated geographical area and is the referral institution for several health centers. Ideally all district hospitals should be equipped to handle all aspects of SV since some are a long distance from provincial hospitals. As explained later in the section of health delivery system all level 4 a 5 institutions should be able to handle all patients presenting there and only refer to level 6 those who need sub-specialties. The standard of preparedness maybe quite different in the various levels of institutions as compared to the ideal as set out by World Health Organization

Some institutions may have capacity in skilled manpower, equipment and medical supplies to manage any number that may need help, yet such institutions might not get any survivors seeking help. Other institutions, maybe due to their geographical location may have to handle several survivors and the quality of their performance would depend on their capacity where skilled staff, equipment and supplies are concerned.

The sheer numbers of survivors and the distribution dictate all level 4, 5 and 6 should be able to comprehensively manage these problems. The diverse cultures in Kenya also dictate that each region can comprehensively manage its own peculiar type of violence for example some institutions will receive complications of FGM and others domestic violence. Only the very complex and requiring special equipment and knowledge should be referred to the Provincial or Referral and Teaching Hospitals.

3.2 Research question

The question was: Do the different cadres of hospitals in Kenya have the capacity in skilled personnel, equipment and medical supplies to handle all cases of GBV that may present to the institution whether in urban or rural set up, even during times of expected higher incidences like in political uprisings? If not what are the major gaps and drawbacks and how can they be overcome?

3.3 Study Justification

GBV occurs all too often and it is becoming increasingly a health problem. The situation is much worse in conflict and war situations. It is imperative that GBV survivors are managed properly to reduce suffering.

This was a baseline audit of health institutions' preparedness to manage GBV survivors comprehensively, with a well organized and effective follow-up program.The findings of the study are useful in informing policy on the constraints and gaps in standardization of the management of GBV survivors. Comprehensive and standardized management of GBV survivors would ensure reduced aftermath such as: Physical disability and death; STI, HIV and Hepatitis B; genital trauma; unwanted pregnancies; initial psychological trauma; post traumatic stress disorders; and suicidal tendencies among others.

3.4 Study Objectives

The overall objective of the study was to assess hospital preparedness to offer comprehensive management to survivors of sexual violence. This was a baseline survey of the current existing facilities in the sampled institutions. This study was specifically aimed at checking the health care delivery system only.

The specific objectives of this study were:

1. To determine the capacity of the outpatient department of the hospital to offer emergency care to sexual violence survivors.
2. To establish the Capacity of Health Information and Record Services to store information for treatment and forensic purposes.
3. To determine the adequacy in numbers and skills of staff to handle medical, surgical, laboratory and psycho-social counseling emergencies of survivors of sexual violence.

4. Determine the availability of adequate and appropriate medical supplies and equipment for Post exposure management
5. Assess the laboratory's capacity to investigate both for treatment and forensic requirements of survivors.

4.0 METHODOLOGY

4.1 Study sites and participating institutions

This study was undertaken in Kenya which has three distinct health delivery systems:

- There are the main private hospitals found in major towns. These institutions are likely to be well equipped and staffed. Some smaller private institutions in urban and rural areas may not be adequately equipped to handle survivors seeking help.

- Faith based health facilities of different cadre are found all over the country. The numbers and complexity of care that these hospitals can offer depend on their location in the country and their main source of funding. These factors determine the quality of the equipments and the qualifications of the staff they can attract.

- Government health facilities are stratified according to the complexity of equipment and specialization of staff. The referral systems in government facilities follow this stratification. At the community level are the dispensaries and health centers. These refer their complex cases to the District hospital which in turn refers to the provincial hospital and finally to the National Referral Hospitals. The District Hospital is the lowest category where all medical aspects can be handled since these institutions are expected to have specialists of all major disciplines.

This study was carried out in the two referral hospitals, selected provincial hospitals, district hospitals, faith based hospitals and a private hospital. It was a cross-sectional descriptive and analytical survey describing existing facilities and comparing with recommendations by Ministry of Health Guidelines management of Rape and Sexual Violence and WHO 2003 guidelines on GBV. The study audited the physical facilities, medical stores, equipment, staff, investigations and records.
In-depth interview of staff directly dealing with the survivors was conducted. Activities at each institution included: inspection of facilities and materials and interviews of various cadres of staff. The responses were recorded in the questionnaire format.

Brief description of the participating institutions:

Kenyatta National Hospital (KNH) is the highest medical institution in Kenya and one of the two referral and teaching hospitals. Situated in Nairobi the capital city of Kenya, it serves a cosmopolitan group both from the city and all over the country.

MTRH is the second Teaching and Referral Hospital in Kenya. It is situated in Eldoret and serves both the residents of the town and the surrounding rural and largely farming communities. Eldoret town and its surroundings were among the most severely affected regions by the post election violence of 2007/2008.

Coast General Hospital is situated in Mombasa, a major port on the East African coast and also one of the three Kenyan cities. This institution serves as the referral unit for coast province and Mombasa town. The culture is dominantly Moslem.

Nyanza Provincial General Hospital situated in Kisumu one of the three Kenyan cities. The hospital serves both the town and the environs mainly fishing communities situated at the shores of Lake Victoria. Kisumu city was severely affected in the post election violence and sustained marked destruction of the buildings in the central business area are still visible.

Nakuru General Hospital in Nakuru municipality the provincial headquarters of Rift valley province. It serves both the town and the environs which are mainly farming communities. Like the rest Nakuru was severely affected by the 2007/2008 post election violence.

Nyeri PGH is the provincial hospital for central province. Found in Nyeri town on the slopes of mount Kenya, Nyeri serves both the town and surrounding farming communities.

Nairobi Women's Hospital in Nairobi is known for management of survivors of gender violence. It gets referrals from all over the country. The staffs in this hospital are committed and proud of what they do. This is a private hospital and receives external funding towards management of GBV in Kenya.

4.2 Variables

This study was auditing institutional preparedness of the Kenyan hospitals to comprehensively manage survivors of GBV and specifically SV.

The variables of the study included:

- Examination rooms that were closable and offered both visual and audio privacy.
- Outpatient and laboratory registers for SV survivors.
- Large non nylon paper to undress on to collect forensic material and non plastic paper bags for storage of same.
- Staff establishment, training and deployment.
- Medical supply for PEP,STI and EC.
- Relationship of medical staff with police, forensic and legal departments.
- Safe shelter, availability and use.

4.3 Organization of Health Delivery Systems

4.3.1 Supervision of Health Services

The ministry of health in the government of Kenya holds the supervisory role of all health facilities in the country, specifically ensuring that proper standards of care and ethics are maintained at all levels, and including private hospitals and faith based facilities. Within the government medical facilities, the control is more direct and centralized.

The recruiting and posting of all personnel into the government health institutions is done from the ministry's headquarters. Any equipment bought for any facility similarly has to be approved centrally from the ministry headquarters. All medicines are sourced for by the government and issued from the central medical stores.

Due to this centralization of resources, one tends to find that there are no major differences in the available personnel, equipments or medicine between similar cadres of medical facilities. Differences will be brought about by the unique practices and believes of the local communities that may determine what supplies are deemed necessary by the

hospital and hence be sourced for eg FGM in some communities in Kenya is not considered a GBV.

4.3.2 Kenya Health institution Organisations

Kenyan health sector comprises two distinct systems;

- The public system which is run by the Ministry of Health and parastatals.
- Private sector which includes private for profit, NGO and FBO facilities.

The public sector accounts for 51% of the health facilities. These are divided into six levels depending on the intensity and complexity of care that they offer.

1) **Level 6 or Tertiary**: These are the two National Referral Hospitals- Namely KNH and MTRH .They are at the apex of Kenyan Health System providing sophisticated diagnostic, therapeutic and rehabilitative services. These two institutions are ideally centers of excellence, providing complex health care requiring complex technology and highly skilled personnel. They have a high concentration of resources and are expensive to run. They also support training of health workers at both pre-service and in-service levels. The equivalents of these in the private sector are the Nairobi Hospital and Aga Khan Hospital both in Nairobi.
2) **Level 5 or Secondary**: These comprise the seven provincial Hospitals and some district hospitals which have been upgraded to level 5 (e.g. Kisii District Hospital) These institutions provide services to a geographically well defined area. They provide specialized care involving skills and competence not available at district hospitals for which they are the referral points. They provide clinical services in Medicine, Paediatrics, General surgery, Anaesthesia, Obstetrics and gynaecolgy, Dental services, Psychiatry, ENT, Ophthalmology, Dermatology, ICU and HDU.

They should also provide:

- Laboratory and diagnostic techniques for referrals from the lower levels of the health care system;
- Teaching and training for health care personnel such as nurses and medical officer intern;
- Supervision and monitoring of district hospitals activities;
- Technical support to district hospitals such as specific outreach services.

3) **Level 4 or Primary Hospitals**:

These are the district hospitals that provide clinical care at district level and are the first referral hospitals from health centers. They provide:

- Curative and preventive care and promotion of health of the people of the district;
- Quality medical care and treatment like surgery not available at health centers;
- Laboratory and other diagnostic techniques and supervision .
- Inpatient care
- Training and supervision as well as resource center for the health enters in that district;
- Obstetrics & gynecology, Child health, Medicine, Surgery, Accident and emergency
- Referral services.

4) **Level 3-Health centers, maternities, nursing homes:**

These are normally staffed by midwives or nurses, clinical officers and occasionally doctors. They provide basic curative and preventive care for adults and children, offer reproductive health services and minor surgical services like incision and drainage. They carry out outreach services and refer severe cases to the district hospital.

5) **Level 2 or Dispensaries and clinics**

These are the lowest level of the public health system and are the first point of contact with the patient. They are staffed by enrolled nurses, public health technicians and medical assistants. They offer ante-natal care and treatment for simple problems in pregnancy such as anemia. They occasionally conduct deliveries and provide basic outpatient curative care.

6) **Level 1 or Interface –Community**;

This is the interface between individuals, households and villages. Major actors include community and faith based organizations, community's own resource persons and community health workers. They deliver health education, environmental health, nutrition and sanitation among others.

There are vast differences in cultures and education particularly of women in the country. This influences how different peoples and regions define gender based violence and how much they are likely to seek medical intervention for the same. To be representative sampling of the hospitals which were visited was done with these differences in mind

4.4. Study Unit

In this current study, the institutions audited were in levels 4, 5 and 6 in the public sector, one private hospital and two Faith Based Institutions. This study aimed at checking the health care delivery system for GBV. Fourteen of the fifteen institutions sampled were audited, while one institution declined to participate in the study. The aspects audited in each hospital were the physical facilities of the OPD, Counseling department, laboratories, theatres, pharmacy and records departments. The individual staff in-charge of these departments was interviewed in a few cases individually as in KNH but in many of the institutions as part of focus group discussions.

4.5 Sampling

Sampling was carried out with a view to represent geographical and cultural diversity, different levels of hospitals and categories such as faith based facilities. All provinces (except North Eastern due to logistics) were covered at some level. The two National Hospitals, which are geographically apart, were audited. While both are situated in major towns and are, therefore cosmopolitan, communities surrounding each of them are culturally diverse. It was also necessary to compare how prepared the two hospitals are since they are the pinnacle of Kenyan health care.

Apart from Nairobi, the other seven provinces have provincial hospitals. Four of these hospitals were selected for audit, taking into account geographical spread. Coast Provincial General represents the coastal communities, mainly Moslem, a religion which is also common in north Eastern. Nyanza and Western provinces were represented by Nyanza Provincial General Hospital. Nyeri represented Central and Eastern provinces, whose cultural backgrounds are fairly similar. Nakuru represented the Rift Valley. These four provincial hospitals also represented the areas that were worst hit by the 2007/2008 post election insurgence in Kenya. Political upheavals are known to be accompanied by sexual violence.

Five district hospitals were audited. Tigoni District Hospital caters for different ethnic communities including immigrants working in the tea plantations. This hospital attended to many post election violence survivors. Gucha and Vihiga represented Western Province. Bondo was representative of Nyanza and Tharaka of Eastern Province. Motomo Hospital in Kitui represented a rural setting of Faith Based Hospital (Catholic) while Supkem Biafra represented an urban based Faith facility (Moslem)

Nairobi Women's Hospital is well known for the large numbers of survivors of sexual violence attended. This facility also handled a big number of survivors of sexual violence from around Nairobi during the post election insurgence. This facility was also included for audit. Some of the hospitals are externally funded to manage GBV. Nairobi women's Hospital receives funding from several sources to run the GBVRC. MTRH has the GBVRC funded by GTZ and the medicines are supplied by AMPATH. Coast General Hospital receives external funding from GTZ whereas Gucha district Hospital is funded by CDC. These differences in institutions were purposively sampled to be inclusive.

A letter requesting approval to visit the institution, the time and the participation of key staff members was forwarded to the institutional heads in advance of the intended visit. The team requested to interview in FGD the gynaecologist, Medical officer, In charge of nursing, laboratory, counseling and outpatient department. These being a hospital setting, the team was aware that not all the requested for staff would be available at the same time. The team therefore interviewed available staff and in some cases conducted in-depth interviews at individual levels.

4.6 Data Collection

Data collected as for the period covering March to August of the year 2009 both inclusive.

The team conducted this survey by:

A. Check list was completed as per the guidance of the questionnaire at all sections.

B. Inspecting the records- registration organization and storage.

C. Inspection of the laboratories- equipment and register of investigations and results

D. Physical audit of amount and expiry dates of various medicines.

E. Interviewing: The in-charge whenever available or a representative of;

i) Emergency care staff,

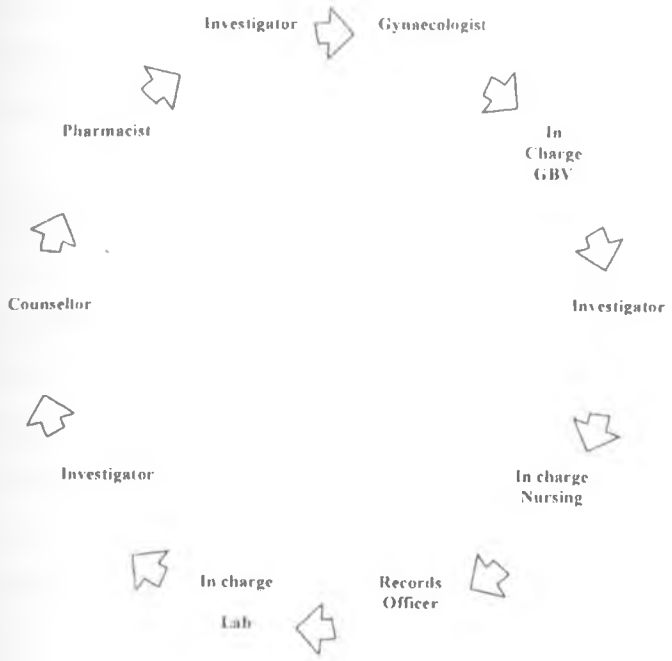
ii) Obstetrician /gynecologist, surgeon,

iii) Nursing officer in charge.

iv) Laboratory in charge and the

v) Person in charge of counseling services.

These interviews were in form of FGD whenever possible. Following is an example of a format for FGD.



The different departments of the institutions were inspected physically and the findings entered in previously prepared and pre-tested questionnaire.

This questionnaire (appendix 1) was crafted from several sources.

- Mainly adopted from WHO guidelines for medico-legal management of survivors of sexual violence (2003);
- It was partly an adaptation of one in the MOH-Kenya National guidelines on medical management of rape and sexual violence.(2004);
- Partly adapted from Trainers Manual on Clinical Care for Survivors of Sexual Violence (MOH 2006);

- From Trainers Manual for Rape Trauma Counselors in Kenya (MOH 2006);
- Partly crafted after reading Liverpool VCT materials on absolute essentials of after rape care;
- Laboratory equipment check list was done with the assistance of pathologists.

The survey was spread out over sixty days' period. There were two teams each consisting of a doctor and a counselor. A schedule of visitation of the fourteen sampled institutions was made. The two teams visited different health institutions simultaneously, sometimes with a supervisor. Data from each facility was compiled separately. When data from all the facilities had been collected, analysis was done.

4.6.1 Recruitment, Training and Pre-testing

A doctor and two counselors were recruited and familiarized with the questionnaire and the tape recorders. Any concerns were addressed and the team was ready for pre-testing. This was conducted at the P.C.E.A. Kikuyu Hospital. This hospital is in a peri-urban setting, and close to Nairobi, thus facilitating convenient access by the research assistants. Prior to the pre-testing the team assembled in the hospital's boardroom to review the tools thoroughly, section by section and question by question and pre-tested among themselves.

The investigator guided the process, addressing each question and confirming that every member of the team understood it similarly. advising about different ways of probing the question accordingly for example during the group discussion after asking about the challenges encountered, one might get more information by asking the respondent what they would change if they had extra available resources.. Once the investigator was satisfied with the enumerators' performance, the actual pre-testing was undertaken.
The team held a feedback session after the pre-testing and arrived several recommendations that were included in the Questionnaire.
Specific identification of the institution and the contact person for any future reference or clarification was included. Some questions which option of 'other' had had to be specific as to what other is. Note was also made whether the employees were full time or part

time and as to whether they had positive or negative attitude to their handling of the investigator and hence a reflection to the survivor.
Emphasis was made that physical inspection of the facility e.g. examination rooms, laboratories and pharmacy had to be carried out at the same time completing the check list. Enumerators were warned not to make any assumptions but to ask each question as it appeared on the questionnaire and write and write down as answered. They were requested to probe further into answers that were not clear without appearing to be judgmental. Institution requested for feedback of the findings and the team concurred that this was important. Therefore enumerators were advised to inform the various institutions visited that arrangements were underway to do this after completion of the study.

In summary the revised tool (appendix 1) was a more easily administered tool, properly numbered for ease of data analysis and allowing for the capture of unexpected responses in the open ended questions and during audio-taping.

4.7 Data Analysis

The completed questionnaires were tallied every evening and according to hospital of origin. The data was then loaded onto a Microsoft excel worksheet enabling easier sorting of data which is in this study presented using tables, graphs, percentage and frequencies. Included also are audio recordings from various heads of departments in the institution which was transcribed as it came from the field.

Following analysis, the data was arranged as per the specific objectives. The results indicated the gaps and challenges faced in the management of SV survivors. From the analysis, the extent of access and utilization of GBV services was evaluated. The study was a check list- only detailing what was or was not available. As there was no hypothesis to prove or disprove, the data was not subjected to any statistical packages or applications. Only tallying against standard expectations and procedures and hence percentages was done.

4.8 Minimization of errors and biases

During training and pre-testing, the research team was exposed to the same high standards and familiarization of the instruments. The questionnaire was revised severally, pre-tested and revised again for easy use and still to cover all required aspects.

The team established rapport with the medical officers in charge of the institutions and with all the different staff they interviewed.

A friendly atmosphere was the basis of the interviews and reassurance that the sole aim of the team was to find common ground with the institution to better offer assistance to survivors.

4.9 Ethical Considerations and Consent

1) Ethical clearance to undertake this research was requested from and granted by the KNH/UON Ethical committee.

2) Written permission to audit the institutions was sought and granted by the Ministry of Health through the Department of Reproductive Health.

3) A letter to each of the sampled institutions was sent requesting permission to visit and to book time to do so. Fourteen of the fifteen sampled gave a positive reply.

These three documents are included in the appendices.

5 FINDINGS

A total of fourteen Health institutions covering various levels as per the Ministry of Health classification were audited. The institutions had a wide geographical and socio-cultural spread, covering all provinces except North Eastern.

The data collected covered a six month period, March – August 2009 inclusive.

A summary of the institutions is shown on the table below.

Table 1 : FACILITIES VISITED.

1. Referral Hospitals	2. Provincial Hospitals	3. District Hospitals	4. Faith based Hospitals	5. Private Hospitals
• Kenyatta National • Moi Teaching and Referral	• Nyanza • Nakuru • Nyeri • Coast	• Bondo; • Gucha • Vihiga • Tharaka • Tigoni	• SUPEM/KEM Biafra • Mutumo Mission Kitui	• Nairobi Women's Hospital.

These are marked on the map overleaf.

Map of Kenya Showing Areas Visited

Key: Visited areas ●

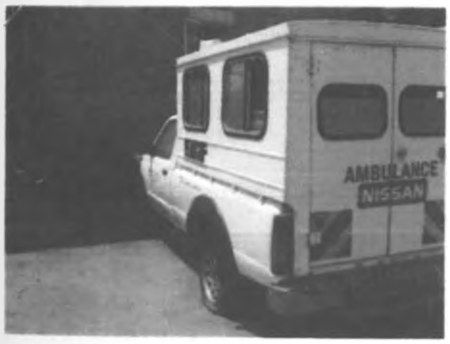
Accessibility

Of special interest is one district hospital which has very few staff of any level (one doctor) and the infrastructure is lacking. The institution has no theatre. When there is a surgical emergency like Caesarean section, the patient gets transferred to the nearest hospital which is 60 kilometers away on an impassible road. The hospital does not have a functional ambulance. Surely under these circumstances, SV survivors cannot be of high priority. The staff, such as was there was welcoming to the investigators.

Picture 1: Tharaka District Hospital

What is visible here comprises the whole of the district hospital. There are no theatre facilities at the hospital.

Picture 2: Ambulance



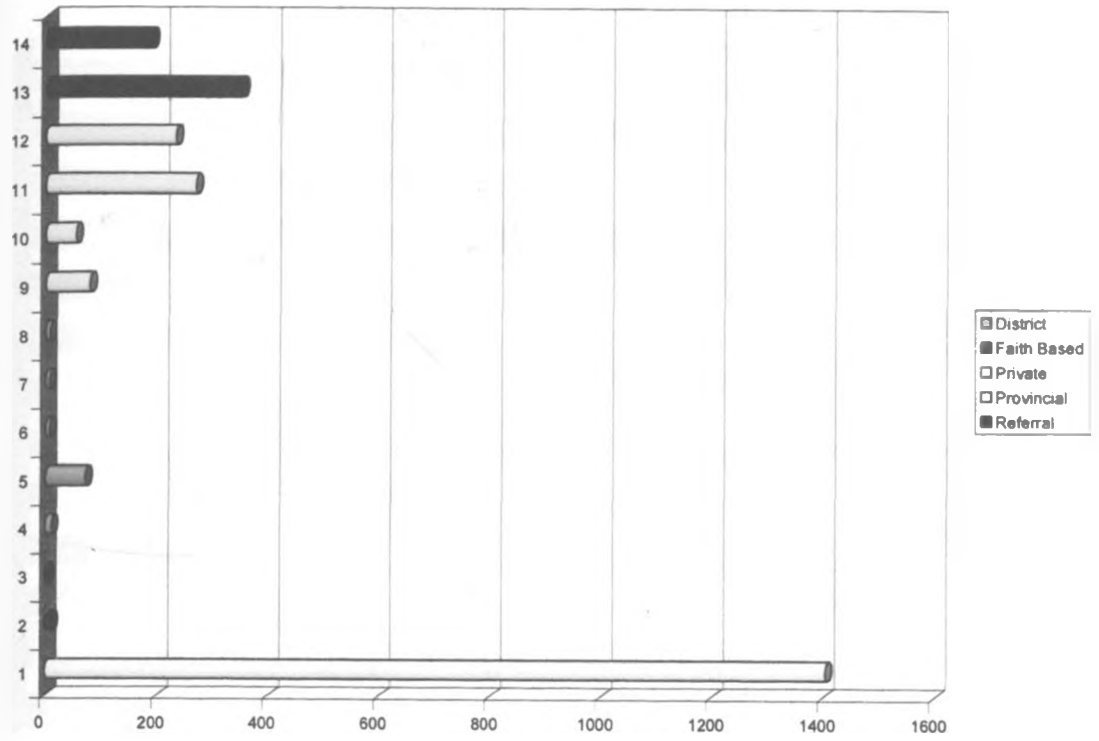
One of the two ambulances at the hospital. None of them is functional.

Picture 3: Road to Hospital

This is the only road used to transport surgical emergencies from the facility to the nearest hospital 60 kilometers away.

5.2 Registered Survivors

Figure 1: Number of registered SV survivors in different cadres of institutions



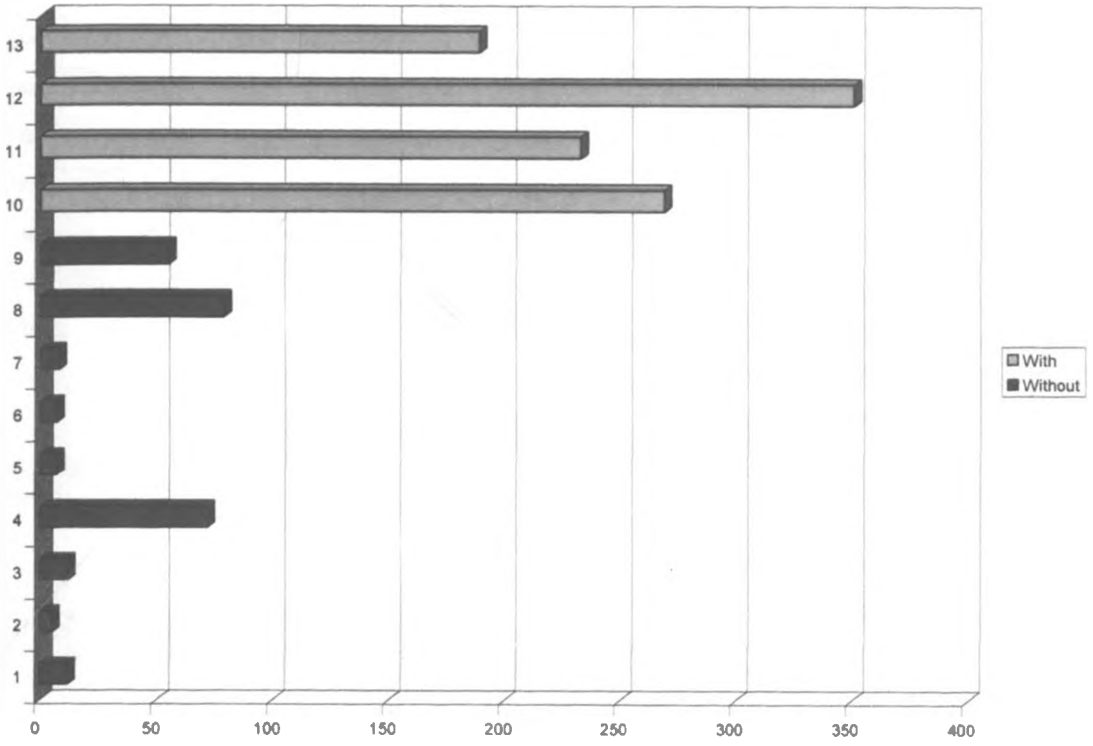
Total number of registered survivors of sexual violence for the period between March and August 2009:

The private hospital handled more then 1400 survivors in the 6 months period. Some facilities handled only a few survivors during this period. There was no facility that had no case of SV.

Institutions with GBVRC –all of which have external funding reported higher numbers of survivors.

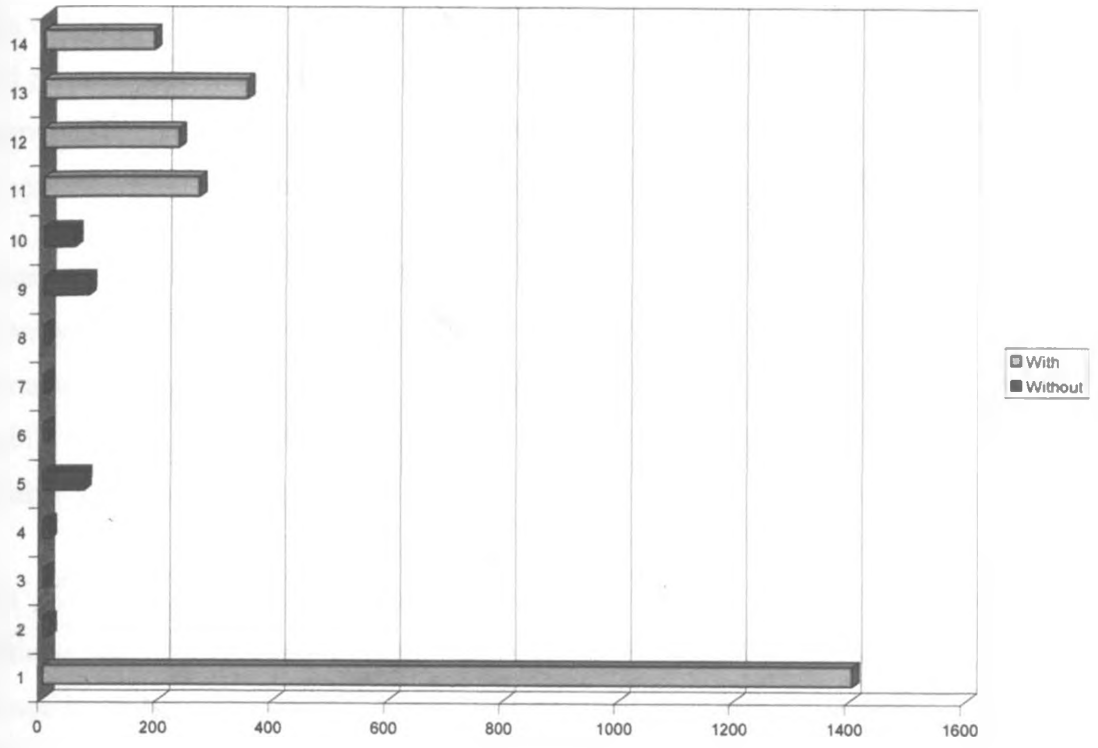
One district hospital had more incidences of SV than two provincial hospitals. This could be due to the surrounding environment which is tea estates with influx of large migrant populations. About 80% of the reported incidences were from tea estates. It would be interesting to audit SV at this institution in depth.

Figure 2: Registered Survivors in institutions with and Without GBVRC (excluding the private hospital)



Comparing the Provincial Hospitals, the above chart shows there are more registered SV survivors in the institutions that have GBVRCs as compared to those without.

Figure 3: Registered Survivors in institutions with and Without GBVRC (including the private hospital)



All institutions agreed that there was definite increase in the number of survivors reporting for management. This was especially since the 2007/2008 post election violence. Asked about the effect on the numbers reporting to hospital after SV a senior counselor at a provincial hospital answered:

Q: ***You said you have been at this institution for a long time, what is the general trend of the number of rape cases?***

A: I think there was an increment last year 2008 because of the post election violence but we are aware that there is an increase in sexually assaulting of the young girls because people believe that if one is HIV infected and has sex with a virgin may be he will be healed of his HIV. I think our traditional values, morals and teachings reduce the rate of sexual assault particularly among children

Last year we had 79 cases after the post election violence from June 2009 we had new cases 153 and revisits 143 in total. In 2006 were 83 rape cases. So the rape cases are increasing may be because now the women are coming out.

This was a common response concerning general trend in numbers of SV recently.

5.3 Meeting the Objectives

5.3.1 OPD Physical Facilities

The SV survivor needs to be relaxed and comfortable during interview and examination. It is necessary to have examination rooms with lockable doors and which provide safety and privacy. The WHO recommendations are that all rooms where SV survivors are examined should have both visual and audio privacy. The two referral and teaching hospitals have several examination rooms that offer privacy in the OPD.

Three of the four provincial hospitals [75%] also have examination rooms that offer privacy in the OPD. In one provincial institution however [25%] the outpatient had only a curtained off area and all patients including sexual violence survivors were interviewed in public as they waited on the queue with everyone else. The examination area offered neither visual nor audio privacy.

All five district hospitals audited did not have closable rooms for examination and patients were interviewed in public with neither visual nor audio privacy. One Faith Based institutions had closable rooms offering both visual and audio privacy. The second Faith Based institution did not have any room that offered any form of privacy.

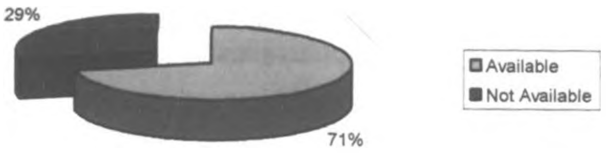
Figure 4:OPD Closable doors

More than half of the institutions audited did not meet the basic WHO requirements of outpatient examination rooms with audio and visual privacy.

Counseling:

Follow up and counseling is vital if a survivor is to recover and get re-integrated to society. W.H.O recommends that counseling rooms must be comfortable and offer complete visual and audio privacy.

Figure 5: Availability of Counseling rooms



Four of the audited institutions including one provincial hospital and two district hospitals did not have any counseling rooms.

Privacy was a bigger problem. Six of these institutions including a referral hospital did not have privacy in their counseling rooms as shown by the figure below.

Figure 6: Counseling room privacy

Over 70% of the institutions had counseling rooms but only 57% had privacy.

Asked about the availability of OPD infrastructure and counseling rooms, a counselor at one of the referral hospitals responded:

"That is a major problem that we do experience; we do not have rooms for counseling. I think the only place I can say we have a room is in CARE, and its only one room. If you go to the wards and other places there are no rooms so we just have to create one for yourself and of course the challenges that are there to be met. We have several patients on one bed sometimes two and to counsel either one of them is a challenge because how will you go about it since the other people might want to listen.

This was a common answer in the public institutions

5.3.2 Records

Sexual violence survivors need proper documentation at first visit and for subsequent follow ups if all aspects of care are to be adequately addressed. These would be found in the outpatient register, the laboratory and the records department. One referral hospital, the private hospital and two provincial hospitals kept proper records. No special coding was done in the outpatient register for sexual violence so the numbers remain unknown. Age of survivors was also not recorded. In the laboratories, there was no special coding for sexual violence so some of the figures given for HIV screening and high vaginal swab are very high because they include all investigations done for various other reasons.

Getting the actual numbers of Sexual Violence Survivors from the outpatient register or the laboratory proved to be quite a challenge. There was no special coding for sexual violence and the survivor could approach the institution from several entry points e.g. casualty, outpatient, consultant's clinics and even the wards. It was to be assumed however that since the institution could perform these tests they were in a position to test the SV survivors. Hence the reason for specifically probing whether the services are free for Survivors.

In one district hospital, the only properly kept records were found in the laboratory where there is a special register for sexual violence. Unfortunately, there is no record of those who turned up at night or on the weekends when the lab was not functional. There are also no records of the survivors who received any other interventions. In all the district hospitals, the records were poorly kept. During the interview with the nursing officer in charge, in one district hospital he/she expressed great concern at the number of

defilement cases they were handling and even wanted support to hold seminars in schools to sensitize the standard seven and eight pupils who would leave school late due to evening tuition. This particular hospital had also completed 20 PRC1 forms in the month of September and October 2008. However, the records for the reported sexual violence survivors in the period of March-August 2009 showed only 7 survivors.

Following was an expression about record keeping:

A). 'Another challenge is that we lack reporting tools, I would like that we have a register where we can keep reports separate from rape reports. This is a challenge because I include all the lab investigations, rape cases in one register. I would wish if I am given reporting tools it would be easy for us to make follow-ups and for all statistics. In the lab we only have one register which contains all the laboratory investigations and that is why I wish I could have a specific register for rape/survivors for putting in my information and keep it somewhere safe.'

The institutions that have a gender recovery centre seem to fare better where record keeping and management of survivors is concerned.

According to the National Guidelines on Management of Sexual Violence, a PRC1 form must be completed for every survivor reporting to an institution. This formal document has detailed information which is useful for medical and psychological follow up and for prosecution of the perpetrator. These are documents prepared and supplied by the government of Kenya. Unfortunately completion of these forms was at best haphazard as shown by the pie chart below.

Figure 7: Institutions completing PRC1 Forms

Completion of PRC1 Forms, shown in the Pie Chart above is an indicator of the commitment to having the survivor get justice. These forms also serve as the comprehensive record in the management of SV.

The diagram above shows that more than half of the institutions (58%) do not complete the PRC1 forms. Only 21% always complete the forms for each survivor. None of the district hospitals had completed any PRC1 form. One provincial hospital also did not complete any forms.

5.3.3 Staff

The two National Referral Hospitals had all the categories of staff members but deployment was a challenge in that the GBVRC were not manned adequately 24 hours. In one of the referral hospitals the attitude of the staff at the GBVRC was not survivor friendly.

All the other institutions did not have the full complement of staff members. Provincial hospitals have large geographical coverage and should have all medical and psychosocial specialists since they are level 5. However, this is not the case on ground and so they cannot be expected to adequately handle GBV. Of the four sampled provincial hospitals, two [50%] do not have pathologists. An even bigger challenge where GBV is concerned is the lack of psychosocial support in way of counselors or clinical psychologists.

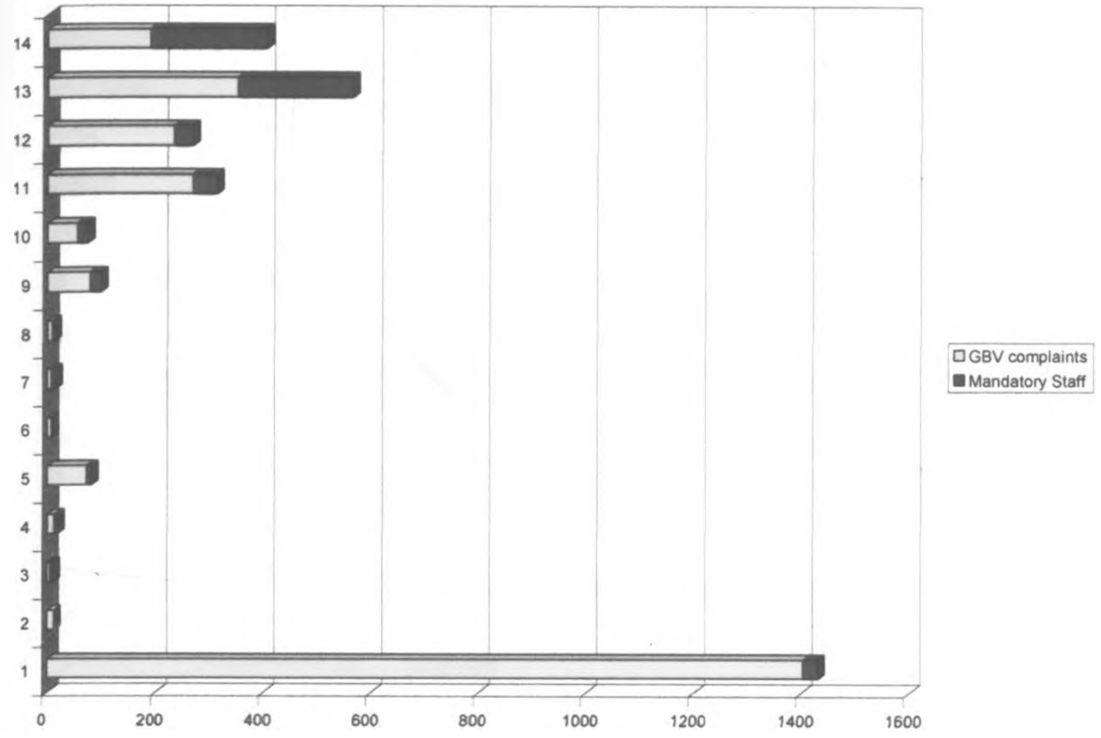
Considering the numbers of patients handled by provincial hospitals, they are all understaffed in the essentials of comprehensively handling GBV.

The District Hospitals are severely understaffed considering they act as the primary referral units. Two of the five audited district hospitals [40 %] had only one medical officer who much of the time is undertaking administrative duties. Three of the five district hospitals [60%] do not have gynecologists. None of the sampled district hospitals have any pathologists.

The private institution audited had the whole complement of staff members. However for the volumes of sexual violence this hospital handles, [1404 survivors between March and August 2009] the hospital is severely understaffed-with only five medical officers and one full time gynecologist and nine counselors. The two referral hospitals have the full complement of necessary staff.

The faith based institutions appeared rather poorly staffed especially in the doctors category.

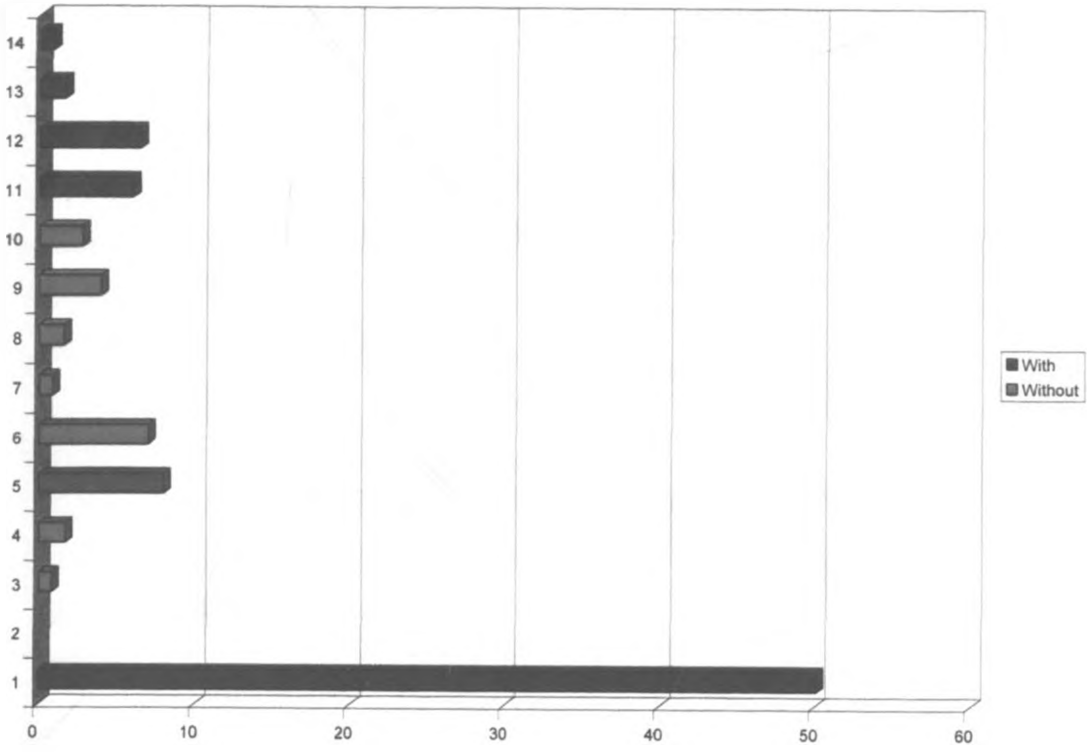
Figure 8: Proportion of Survivors to mandatory emergency staff



When SV survivor reports to hospital as an emergency, there is the minimum staff requirement to attend to her/him. There should be a medical officer, a clinical officer or a gynaecologist to carry out the examination and collect specimens and a lab technologist to check the specimens. These are categorized together as the mandatory emergency staff.

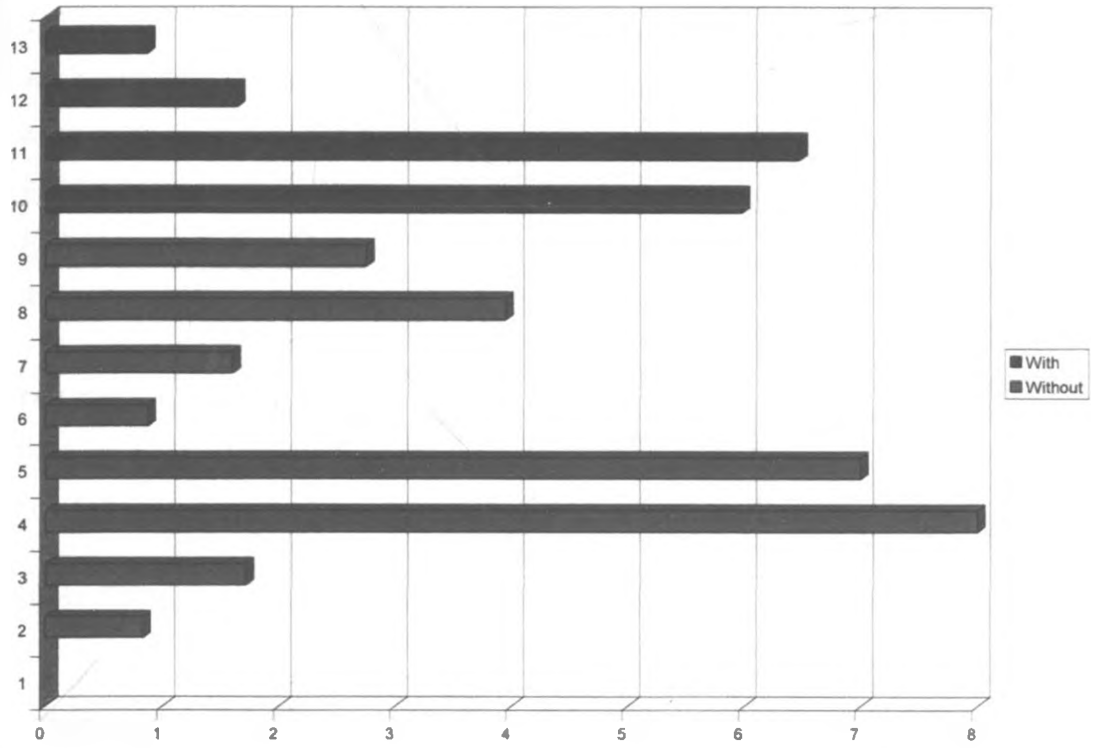
In the diagram above we can see that the hospitals with the best proportion of survivors to emergency mandatory staff are the referral hospitals. One hospital has very many survivors in proportion to the few emergency mandatory staff. In some hospitals we don't find any of the mandatory staff or only one person or one category of the mandatory staff.

Figure 9: Proportions of survivors to staff in centers with and without GBVRC



This diagram illustrates that the hospitals with GBVRC and which receive higher numbers of SV are not better staffed. The staff ends up handling more survivors. There are two district hospitals that do not have the whole complement of mandatory staff and yet handle many SV as shown in institutions numbers 5 and 6.

Figure 10: Proportions of survivors to staff (Excluding the private hospital)



The referral hospitals have the lowest number of survivors to each mandatory staff. The private hospital has the highest ratio of survivors to staff 50:1 One district hospital had many SV (72) with only (9) mandatory emergency staff.

5.3.4.Psychological Support

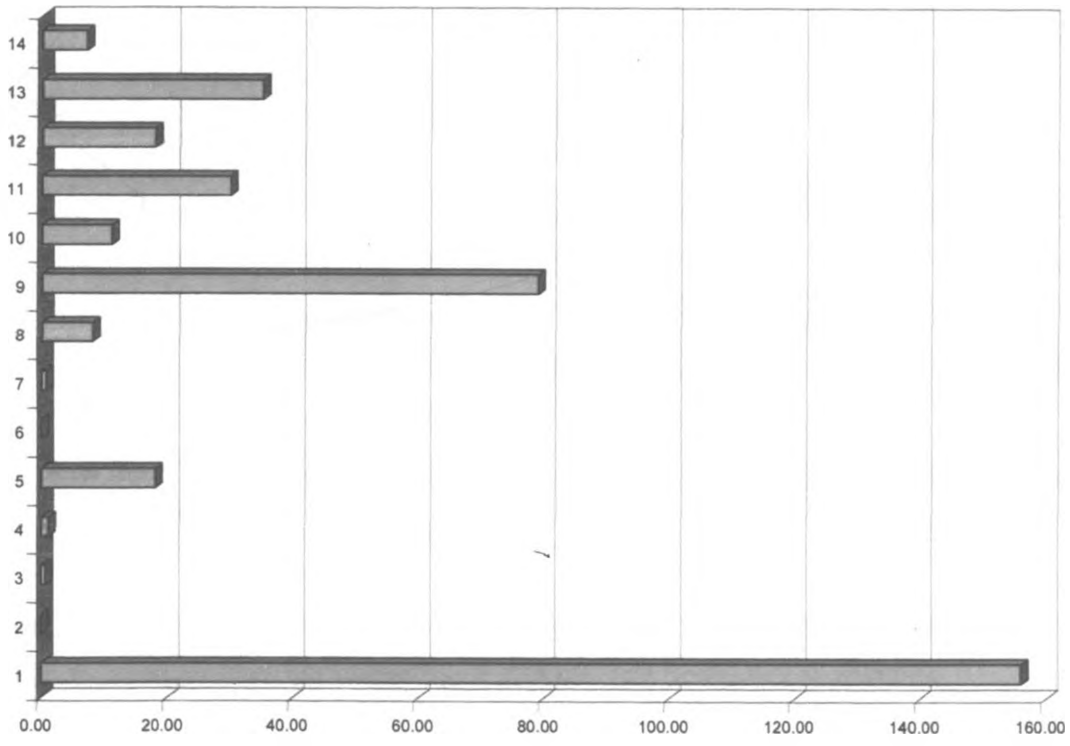
Psychological management of the sexual violence survivors cannot be over emphasized. If not adequate, the survivor will never recover fully from the ordeal. In 25% of provincial hospitals and 75% of district hospitals of the institutions visited, psychosocial care is poor. The counseling rooms are inadequate and have no privacy. The staff members are also not sensitized to the problem of sexual violence. In only one provincial hospital, 8% of the institutions, did the enumerators find a diagram at the outpatient gate directing all those reporting to the hospital after sexual violence as to the steps they would take and where these would be available. In this particular hospital even the guards are sensitized to handle and direct the survivors. The medical superintendent of this hospital has gone an extra mile to comprehensively manage sexual violence.

The numbers of counselors at the private hospital are inadequate. The hospital has six counselors who are too few to adequately handle the numbers of sexual violence cases

[1404 in a period of 6 months] they receive. There are no counselors trained to handle children and in any of the institutions including the referral hospitals and yet in all institutions the sexual violence is about 50% defilement. Only four institutions [32%] have follow up sessions. In most institutions, counseling is not at all done or if at all, only as an insignificant part of the history taking and examination by the medical staff. In one district hospital, counseling is never done and yet due to the locality among tea estates, a lot of sexual violence is reported. One referral hospital has only two counselors directly managing survivors and they are not available at night.

Debriefing of the counselors and other staff handling sexual violence is in most institutions absent or at best haphazard. They self debrief among themselves. A few hospitals (three of the audited) have structured debriefing sessions once a month.

Figure 11: Proportion of SV/Counselor



At one hospital the proportion of survivor to counselor is 156:1.

5.3.5.Availability of Medicines

Medicine availability is another concern for care of sexual violence survivors. All the institutions were well versed and well stocked with the post exposure prophylaxis drugs. These were supplied free in all the institutions. The challenge was giving them within the 72 hours. Some survivors would report late. Some institutions would have no staff to deal with sexual violence overnight and during weekends. Some survivors would be requested to 'come back tomorrow' and would there by be lost to follow up.

Emergency contraception is also easily available in most of the institutions and most of them use P2. It is free. The exception was the Catholic Faith Based Institution which does not stock any form of contraception.

Prophylaxis against sexually transmitted infections is poor. Three quarters of district hospitals do not have the necessary drugs especially where treatment of children is concerned. One hospital [25%] was well equipped with drugs as it was being specially supported by an NGO.
The provincial hospitals have the necessary drugs but these are not administered uniformly for free. Faith based institutions do not have the prophylaxis against STIs.

One Referral Hospital has adequate drugs and these are offered free. This institution is also supported by AMPATH and is adequately supplied with drugs for all conditions. They are also available 24 hours. The private hospital also has adequate amounts of drugs, free and available 24 hours. The other referral hospital has all the drugs which are required and are given free to survivors.

To find out the stocks of pharmacy was complicated by the fact that the medicines for STI prophylaxis, PEP and EC were stored in different places and departments. Both Referral hospitals had separate adult and children sections in their main pharmacies. There was no separate section in the pharmacy for adults and children in all the other institutions.
The worst hit by lack of drugs were the district hospitals and especially concerning STI prophylaxis and treatment:

Q. ***'what challenges do you face as a pharmacist related to GBV particularly rape?***
A. The main challenge is lack of drugs especially post rape STI drugs. We have not had much trouble with PEP ARV's. Those are available almost always but the other post rape STI cases mostly antibiotics most of the time they are not there.

Erythromycin is broad spectrum and can be administered both to children and adults.

It is therefore being charted above to represent availability of STI prophylaxis.

More than 70% of the institutions do not have erythromycin syrup.

At the time of audit, the Government hospitals did not have amoxicillin syrup the alternative that can be used in place of erythromycin. KEMSA had not yet supplied.

Figure 12: Availability of Erythromycin Syrup

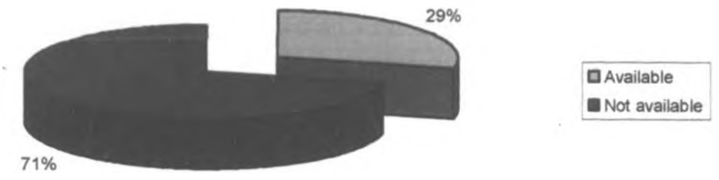


Figure 13: Availability of Erythromycin Tablets

More than half of the audited hospitals had tablet Erythromycin

The two referral hospitals and all the provincial hospitals had capsules of amoxicillin. Two district hospitals did not have amoxicillin capsules. The adults who report with SV are able to get medication. The major problem is in the under five age group who would require syrup.

The two referral hospitals had enough drugs for all aspects of SV survivor management. These were also supplied free of charge in these institutions especially through the Comprehensive care centers.

Stores:

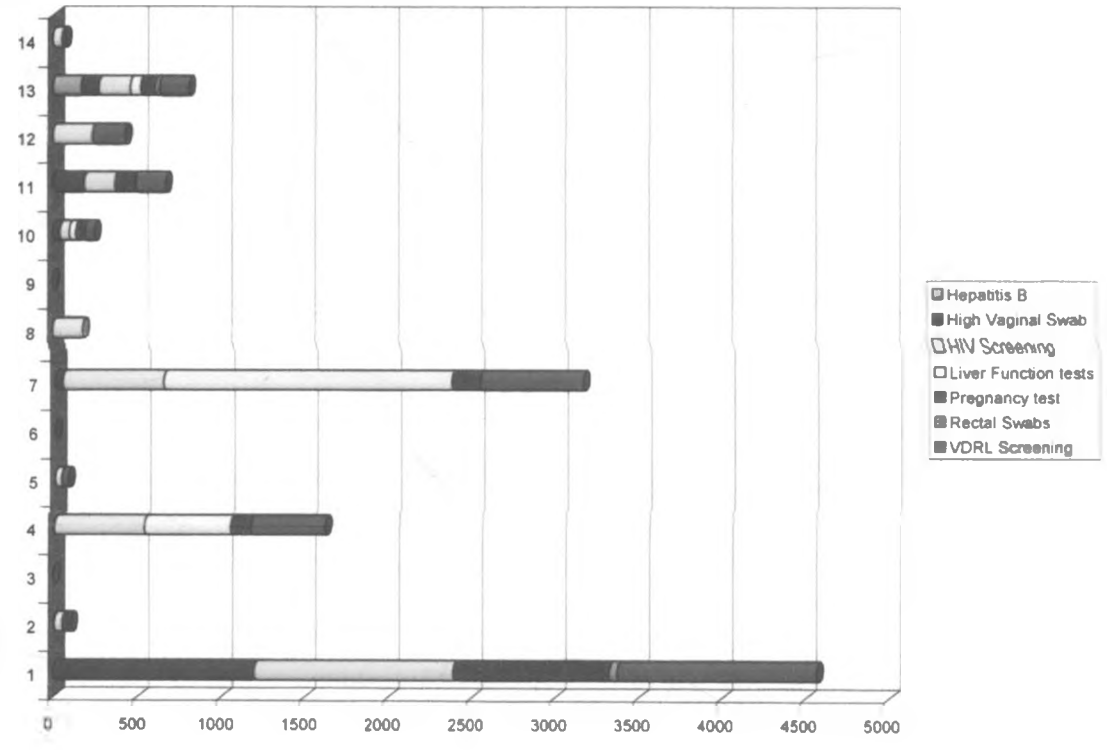
Only 33% of the institutions had enough drugs and materials to last one month at normal consumption. These included the medicines for STI which were missing in several institutions and also laboratory and theatre supplies. Only the two referral hospitals had adequate supplies. None of the district or Faith Based Institutions had any supplies in store.

5.3.6. Laboratory back up and Forensic

The preparedness of all the institutions in this particular aspect of care is poor. No institution has the large paper for the survivor to stand on as they undress to collect debris. The hospitals do not collect forensic evidence because they do not know how or where to store and the correct procedure to give evidence. There are no proper lockable storage facilities. One hospital has cartons full of forensic material which has not been analyzed several months after collection. Some of the survivors who are brought to the facilities by the police take the forensic evidence with them. There is no clear chain of custody of the forensic material of those who are not initially brought by the police.

Collection of the forensic material also poses a challenge for many institutions. Functional equipment in the laboratory is missing. In one district hospital there were no gloves; which makes examination of the patient or collecting the specimens impossible. In another district hospital, there were no swab sticks. They could not assemble any locally as they did not have a functioning autoclave. The speculums could also not be sterilized.

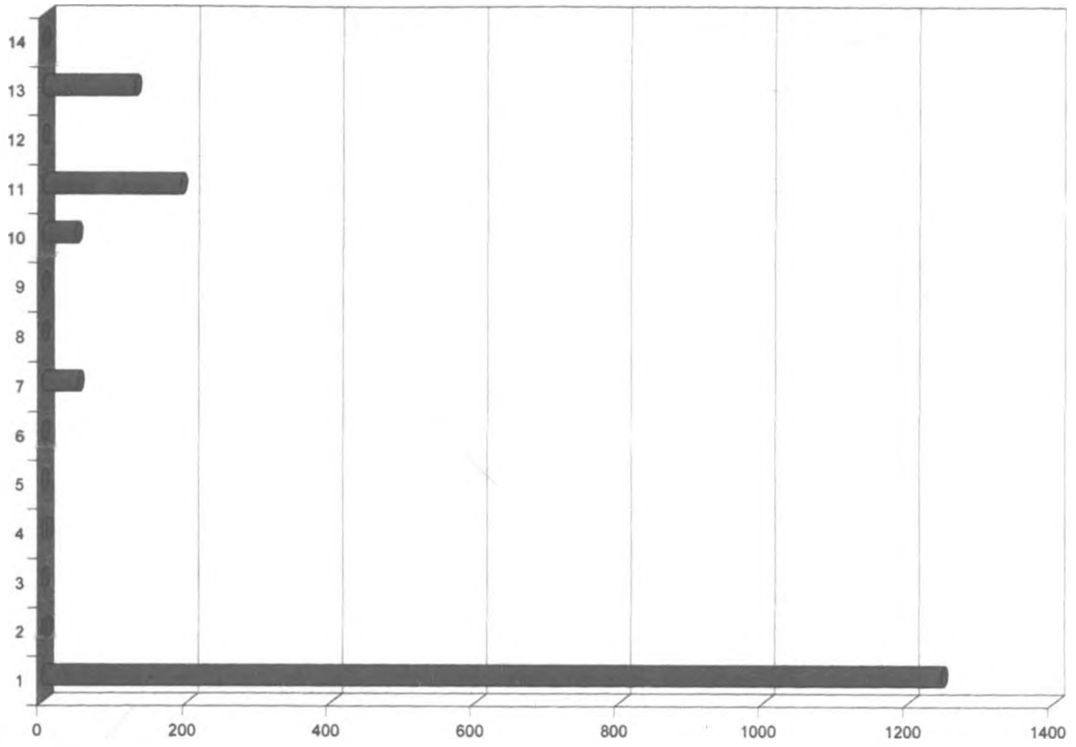
Figure 14: Laboratory Back Up in different institutions.



In the above diagram some institutions are not well represented as record keeping in the laboratory and special coding for SV was missing. Tests like liver function were being carried out for all patients who were receiving ARTs and not only those on PEP.

High Vaginal Swabs and Rectal Swabs are recommended by W.H.O. and the Kenya National Guidelines to be collected for each survivor of SV for screening for STI and also for DNA analysis. These were not collected by most institutions and even when collected it was not from every survivor.

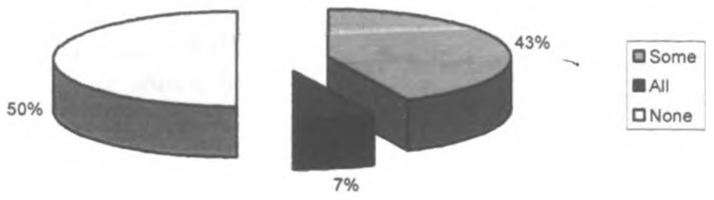
Figure 15: Numbers of HVS or RS collected by different institutions.



Only two district hospitals collected any HVS or RS

The records of one referral hospital for RS/HVS could not be ascertained as there was no special coding for SV.

Figure 16: Proportion of institutions collecting HVS or RS .



Only the private hospital collected these all the time. Another 6 institutions did not collect any.

Although some institutions collected many HVS and RS, they were never presented for evidence or STI screening. They ended up in cartons that were not properly labeled and not forwarded as evidence.

Many public institutions faced challenges not only with storage of forensic material and proper chain of custody but also in collection. The issue of the 72 hours cut off was also a challenge in collecting laboratory materials. One in charge of a laboratory had this to say and this was a common answer.

Q: Tell us, what are your main challenges in the lab as laboratory in-charge as you handle the survivors of rape?

A: We are facing some challenges since there is an increase of rape cases. One major challenge is the delay of the survivors reporting because as you know the laboratory should give out evidence of the rape within 72 hours but some of the survivors come after three days when they have bathed meaning that it would be difficult to see for instance any spermatozoa as evidence to rape.'

5.3.7 Legal and Justice

The relationship between the various departments that should ideally be involved in the comprehensive management of the survivor is at best strained or non-existent. It is then not surprising that most institutions do not complete the PRC1 forms. These forms form the baseline for completing P3 forms that the police department uses for prosecution. No wonder then most perpetrators do not ever get prosecuted.

Encouraging report on the relationship between police and Health institutions was found only in one referral hospital. The typical answer in the other institutions was:

Investigator: *'What would you say is the hospital relationship with the department of the police, legal and the administration?*

Response by a doctor at a provincial hospital:' Do we have a relationship? (laughter from all').

Some cases of SV or even GBV will be unreported. This could be due to ignorance or lack of awareness that something can be done. At times the family may be unwilling to pursue the matter. Following is a response to a question as to why SV is unreported in a certain community and why legal recourse is not sought.

Response;

'In this region most of the disputes are solved at the family level. Most of the cases where the children are raped, it's either done by the uncle, the cousin or somebody staying within the family. They think that by accusing the victim, they will be spoiling the family name so they want to guard the family name. It's a cultural thing. Most of these people don't think that rape is traumatizing.

A number of survivors were brought by police and legal follow up may have been done. For those not brought by police, there is no involvement of the police or legal system within the institution. PRCI forms which would assist are not completed. P3 forms are completed for those brought in by the police. In some of the institutions, P3 forms are completed on specific days and some money charged for this service. Three of the fourteen institutions [23%] consistently complete PRCI forms and give them to the survivor to follow up with the police. There are however 5 different types of these tools being completed amongst the institutions audited. There is the government one; there is one for Nairobi Women's Hospital, one for Moi Referral Hospital and one for Nakuru and one for Coast General Hospital.

5.3.8 Shelter and Outreach

None of the health institutions have a safe shelter either within the hospital or away where they can house those survivors who are running away from the abusive home that also houses the perpetrator. The private hospital is associated with a few homes that can offer temporary shelter if they have space. The referral hospitals admit children in the general pediatric wards until such a time as shelter is found. No organized safe shelter was associated with any institution.

One referral hospital has a program Funded by GTZ that purposely does outreach to sensitize communities and to follow them up. The private hospital gets publicity through the media. The other audited health institutions do not have an outreach or follow up program.

5.3.9 Service Provider Attitude

GBV and specifically SV is a growing problem in the Kenyan Society. The outcome of not managed or poorly managed cases could result in serious long term outcomes like HIV, loss of reproductive capacity and permanent psychological trauma. Communities need to be sensitized as to the availability of these services and to the willingness of medical personnel to be helpful and to handle each survivor with compassion. Unfortunately this is far from the reality on the ground.

Most of the institutions visited were very welcoming to the enumerators and answered all their questions freely without reservations. One felt the survivors were welcome in that institution. One Faith Based Hospital administration denied the team access to the institution to audit it even after several phone calls and letter writing.

The staffs at the Patient Support Centre of one referral hospital were clearly unwelcoming to the enumerators who were left feeling as intruders although ample forward planning had been done and notice of intent to visit given in time. One was left wondering the kind of welcome survivors of SV receive there. Three departments within this institution were quite helpful towards this research. These were ; The Senior Administration of the Hospital for giving the authorization letter without delay, the Administration and Counseling departments of Casualty who were willing to answer all the questions freely and the Chief Pharmacist who was very helpful and instructive.

Challenges-For Researcher

The greatest challenge was records. In more than 50% of the institutions the records were poor and scattered all over general registers. In some of the hospitals, specific numbers of either survivors or counseling sessions could not be ascertained. It took sometime to run through the various locations in the hospitals to get the records .This begs the question how the clinician can complete the records daily as he works and how reliable the records are.

6 DISCUSSION

One of the objectives of this study was to establish the then current infrastructure of these fourteen hospitals as a sample indicating the expected state of all the other institutions. The only institution with closable outpatient examination rooms and counseling rooms that offer privacy was the main referral hospital. All the other institutions including the other referral hospital either lacked the facilities all together (one provincial hospital and all the district hospitals) or the rooms did not offer privacy. This situation should be urgently addressed. The number of SV survivors reporting to hospitals is increasing. It is imperative that the infrastructure be survivor friendly to ensure the dignity that the survivors deserve. These are already traumatized people and interviewing them in public traumatizes them all over again.

None of these institutions offered toilets (only the public ones) shower facilities or a change of clothes to the survivor after examination as per W.H.O. recommendations.. Ideally the clothes that the survivor was wearing during the SV ordeal should be packed safely in non-nylon paper bags awaiting forensic review. No hospital had those non-nylon paper bags. No hospital had the large paper on which to undress in order to preserve debris for forensic.

The infrastructure also needs to be child friendly and indeed overall survivor friendly. None of the institutions had toys or play pens for the young survivor. The examination rooms and couches were all adult.

Of interest in this study was how the various institutions run their Health information systems and kept their records. Only four institutions (one referral, the private hospital and two provincial hospitals) kept complete records. One referral hospital did not have any special coding for SV and it was impossible to assess the numbers from outpatient registers. Information gathered at this hospital was obtained from the nurse/counselor in the casualty department and whose consulting room was only accessible during official working hours. All the other hospitals did not keep complete records.

PRC1 forms if completed would assist in record keeping and follow up of the survivor. Without this form, it is impossible to ascertain if the survivor received PEP, STI prophylaxis, emergency contraception where required or psychological support. The numbers of survivors that get lost to follow up, as to whether they complied with uptake of PEP, sero converted to HIV positive cannot be deduced. As to whether a survivor develops STI, becomes pregnant or seeks court redress for punishment of the perpetrator remains unknown.

Staffing of these institutions with the full complement of different disciplines involved in comprehensively managing the SV survivor is one of the check out objectives of this study. These are qualified staff to man the OPD, laboratory, theatre and for psychological support. The attitude of the staff members was generally positive in most cases.

None of the district hospitals had a gynaecologist so all complicated sequel of SV would have to be referred to the provincial hospital. District hospitals had one or two medical officers mainly carrying out administrative duties. One provincial hospital and all district hospitals did not have a pathologist. The two referral and two provincial hospitals had trauma trained counselors. A Faith Based and one district hospital did not have any counselors. All the other institutions had only general counselors. None of the institutions had any counselors trained to deal with children.

Post Exposure prophylaxis for adults was available in all institutions. The challenge in PEP was the 72 hour cut off as survivors would sometimes present too late and also the age group that could only take syrup form although nevirapine was uniformly available. Prophylaxis against STI was available in all the hospitals for adults and there was variety. There was a major problem for children. There are two recommended drugs; amoxicillin and erythromycin. None of the institutions had amoxicillin syrup. It had not been supplied by KEMSA for about three months. Five institutions had syrup erythromycin. The other nine hospitals did not have syrup erythromycin and so a child reporting there with SV would not get appropriate treatment.

The only district hospital that could run the full complement of investigations required post SV including liver function test was enabled by external funding from CDC. This was also the only district hospital that could collect HVS or RS. All the other district hospitals could not perform these basic investigations so as to comprehensively manage

SV. The provincial and referral hospitals are well enough equipped to carry out the necessary investigations.

Many of the institutions have a positive attitude to handling survivors of SV. It was encouraging to see the effort one provincial hospital which did not even have a GBVRC was making to comprehensively handle the survivors even with shortage of resources. All institutions registered interest to improving their management of SV survivors and would welcome additional input.

The two National referral hospitals and the private hospital might be the only ones reasonably equipped to handle the more severe cases of GBV. It is imperative that staff of each medical institution understand the local protocols and rules that govern the provision of medico-legal services to the survivors. Considering the numbers of patients handled by provincial hospitals most of them are understaffed in all categories of staff dealing with SV survivors.

The private hospital has the full complement of mandatory staff. However for the volumes of sexual violence this hospital handles, [1404 survivors between March and August 2009] the hospital is severely understaffed-with only five medical officers and one full time gynecologist. The nine counselors employed by the hospital must also be grossly overstretched.
The SV survivor needs to be relaxed and comfortable during interview and examination. It is necessary to have examination rooms with lockable doors which provide safety and privacy. The referral and provincial hospitals had these physical facilities with the exception of one where there was no room leave alone privacy. All district hospitals were not physically prepared.

All institutions had the drugs required for PEP for adults. Syrups were not always available. Emergency contraception was available in all institutions except the Catholic Faith based institution where they do not stock any kind of contraception. This is indeed commendable. The challenge was giving them within the 72 hours. Some survivors would report late. Some institutions would have no staff to deal with sexual violence

overnight and during weekends. Prophylaxis against STIs was not uniformly available especially in the hospitals supplied by the Government Central Medical Stores and may not always arrive on time. Most of these would also be given to the survivor at a fee.
Sexual violence survivors need proper documentation at the first visit and for subsequent follow ups if all aspects of care are to be adequately addressed. These would be found in the outpatient register, the laboratory and the records department. These records were in general inaccessible.
Specific training of all cadres of medical staff, the police and the legal arm of the government in handling gender based violence should be implemented in their curriculum and continuous education.
Psychological management of the sexual violence survivors is very important. If not adequate, the survivor will never recover fully from the assault.
The number of counselors is inadequate. Debriefing of the counselors and other staff handling sexual violence is absent or at best haphazard. They self debrief among themselves. The exceptions here are the private institution and the two Referral Hospitals where there is structured debriefing once a month.
Counseling rooms with privacy were present in the one referral hospital, two provincial hospitals and two district hospitals. One provincial hospital had the closable rooms but there was no ceiling and the rooms were hence interconnected. One provincial hospital and three district hospitals did not have counseling rooms.

The Child Survivor:

None of the institutions had child-friendly outpatient departments or even examining areas and yet according to the records in the hospitals 47% of the SV cases are defilements. Reception of children needs to be special in physical facilities and in the training of special cadre of staff to handle them. Management of the very small ones- below 10 years is especially crucial as they may even need examination under anesthesia. Children need a voice that will not tire fighting for them.

The perpetrator

Interviewed staff all over the audited institutions felt that the issue of the perpetrator was very poorly handled and that most survivors do not get justice. The one stop center for

handling survivors of SV such as Thuthuzela in South Africa is ideal since it is survivor oriented. They offer transport to the survivor both to and from hospital back home or to a safe shelter. There is a unit in the hospital where Thuthuzela offers a unit in the hospital where the survivor finds a medical team, the laboratory, counsellor, police and even the advocate to handle the case and proceed to court. In Kenya the situation is different. A survivor reports in casualty where after a period of waiting on the queuing they are examined and possibly sent to the laboratory department where they might need to narrate the ordeal all over again. If PRC1 form or P3 is completed they take it to the nearest police station where they find whichever officer on duty and who may not be trained to handle SV survivors. The survivor gets more traumatized and quite often the matter will never gets to court.

All health institutions of level 3 District hospitals, Provincial Hospitals and referral should have or be associated with a safe shelter for those of the survivors who risk being traumatized again if they return to their current environment

7 CONCLUSION

The audited institutions show a generalized lack of preparedness in comprehensively managing survivors of SV. Infrastructure that offers space and privacy is lacking. All the facilities require infrastructure upgrading. All audited institutions need to keep proper records and have standard coding for SV. Only a few institutions complete the PRC1 forms for each survivor and these forms are not standard, with different institutions completing different forms. Lack of completion of these forms translates to lack of clear medical and legal follow up thus facilitating the perpetrator to evade prosecution.

Qualified staffs in adequate numbers are found in only in one referral hospital. However the deployment is unequal. There were six counselors and two clinical psychologists handling six survivors per week at the GBVRC as compared to one Nurse/Clinical psychologist, handling eight survivors per week at the casualty department. The attitude of the staff at the GBVRC in this particular hospital towards the enumerators left a lot to be desired.

All other institutions including provincial hospitals did not have the full complement of staff. Counselors are few with inadequate debriefing. There are no trauma counselors or any specifically trained to handle children. Apart from the two referral hospitals and one district hospital there is lack of essential drugs especially STI prophylaxis for children.

Record keeping is poor with no special coding for SV in any of the departments.

Forensic material if collected is not properly stored. There is no proper chain of evidence and the link between the medical and criminal justice system is weak. There are no safe shelters for survivors and no hospital had a shower or change of clothes.

The W.H.O. guidelines on Management of Sexual Violence and the Kenya National Guidelines developed by the Ministry of Health revised 2009 on management of Sexual Violence are not being implemented in the audited hospitals.

8 RECOMMENDATIONS

8.1 Institutional -Medical Officer in Charge of institution to ensure that:

- Referral systems should be strengthened for hospitals that are not able to handle and manage various survivors.
- There should be regular supervision and debriefing of health workers and counselors.
- Records keeping for each institution should be streamlined for the whole country and for all health institutions
- Special coding for Sexual Violence should be introduced.
- Departments handling survivors of sexual violence should be operational 24 hours including weekends and public holidays.
- Where a recovery centre is supported by an NGO, effort should be made to integrate it in the normal running of the institution and employ different staff of the hospital on a rotational basis. It should not be seen to belong to a certain few members of staff who are paid an allowance to run it.
- Institutions should endeavor to be child sensitive in counseling, examination, admission, beds and drugs.
- Forensic training of health workers to provide a chain of evidence should be undertaken.

8.2 Ministries and Government Departments:

- Ministry- makes GBV management a priority and adopts the *Thuthuzela* one stop concept
- Improve physical facilities to ensure privacy.
- Adequately staff hospitals-especially district level with medical officers, clinicians, and nurses.
- Adequately equip all laboratories at district level.
- Give guidance on chain of custody of forensic materials and make completion of P3 forms free.
- Merge the ministry's PRC1 form with the others used in various institutions to make one common tool.

- Establish GBV recovery centers in all the district level and bigger health institutions.
- Enable institutions to do outreach in their communities.
- Provide constant and free supply of drugs for prophylaxis against STI
- Establish safe shelters.

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APPENDICES

A. Tools of data collection

The semi structured questionnaire is divided into sections and departments for ease of administration, collection and analyzing data.

QNO_____

BASELINE SURVEY OF HOSPITALS PREPAREDNESS TO PROVIDE MEDICAL AND PSYCHOSOCIAL CARE FOR GENDER BASED VIOLENCE SURVIVORS IN SELECTED SITES IN KENYA

August /September 2009.

Enumerator_____

Date _____

Identification

1 Name of Health Facility _____

2 Province where Facility found _____

3 Type of Health Facility

[ ] Provincial

[ ] District

[ ] Faith Based

[ ] Other Specify_____

4 Predominant Ethnic Group _____

5 Contact Person: Name_____Title_____Telephone_____

6.	**Staff attached to the institution as either full time or part time consultants:**	**Full time (Number)**	**Consultants (Number)**	**Total (Number)**
i.	General Doctors			
ii.	Surgeons			
iii.	Gynecologists			
iv.	Pathologists			
v.	Anesthetists			
vi.	Clinical officer Anesthetists			
vii.	Lab Technicians			
viii.	Lab Technologists			
ix.	Clinical Psychologists			
x.	Counselors			
xi.	Counselors specific for Trauma			
xii.	Others Specify.....			

Departments

Outpatient Department –Ease of Flow.

7 Do survivors of SV have a special reception area where they are received?

[Yes] [No]

8 Is there easy access from registration to examination room? [Yes] [No]

9 About how many minutes pass before a survivor is registered in the institution?
_____

10 About how many minutes pass from registration to examination?
_____

The examination Area Check List

Tick whichever appropriate:

11 Presence of a discreet private examination room with a lockable door
..... [Yes] [No]

12. A separate room containing a table and chairs where a support person or counselor can talk to the survivor [Yes] [No]

13 Shower and toilet for survivor [Yes] [No]

14 A room for police [Yes] [No]

15. A reception area where accompanying family members and friends can wait [Yes] [No]

16.1 At the outpatient department, are rape kits available? [Yes] [No]

16.2 If yes, how many? _____ 16.3 Are the kits imported or locally assembled? _____

17. Is a large-paper to stand on while undressing to collect any important forensic debris available? [Yes] [No]

ABSOLUTE ESSENTIALS FOR A POST RAPE KIT

(No answer was expected at the area of [Absolute Essentials for a Rape Kit], the inclusion of this section was for the enumerator to familiarize themselves with the contents of, and be able to check availability and completeness of Rape Kits.)

- A record to show the steps of evidence collection.
- Powder free gloves
- Swabs minimum six in number
- Sterile containers for specimens
- Appropriate labels(can use masking tape)
- Glass slides
- A starter pack of:6 doses of PEP
  : 2 doses of emergency contraception
  STI prophylaxis drugs
  : An anti emetic
- Envelopes and brown paper bags.

Outpatient Register in the last six months:

Please quote actual numbers

18 How many complaints of GBV were registered? _____

19. Type of Violence .....[Rape] [Domestic] [FGM] [Other] (Specify)

20	**Age categories of the Survivors .....**	**Age Category**	**Violence type**	**Number**
	< 5 years (infants and young children)			
	5 – 12 years (children and pre-teens)			
	>12 - <= 18years (teens)			
	>18 - <= 45 years (young adults and adults)			
	> 45 years (post menopause)....			

21 How many duplicate PRC1 forms have been completed? _____

22. Number of completed P3 forms ..._____

Radiology

23 Presence of functional;

(i) X-ray Machine..... [Yes] [No]

(ii) Ultrasound Machine.....[Yes] [No]

(iii) CT scan/MRI Machines..... [Yes] [No]

Laboratory

24 Presence of Functional:	[Yes]/ [No]	Number
(i) Microscope		
(ii) Elisa Machine		
(iii) Swabs		
(iv) Rapid Kit for Khan test (VDRL)		

Laboratory Register

25 Within the last six months how many of the documented GBV survivors underwent the following? Please quote actual numbers.

Procedure	**Number**
(i) HIV 1 & 2 Screening	
(ii) VDRL Screening	
(iii) Pregnancy Tests	
(iv) High Vaginal Swab	
(v) Rectal Swabs.	
(vi) Liver Function Tests	
(vii) Hepatitis B Surface Antigen Screening.	

Theatres

26 Number of Theatres _____

27 Number of Theatre Nurses _____

28 Porters _____

Theatre Register

29 Number of GBV surgical interventions in previous six months prior to study._____

Pharmacy

30 Are there separate Adult/Children Sections in the pharmacy?..... [Yes].....[No]

Specifically for Prophylaxis of STI in Survivors of Rape, are the following available?

31	**Drugs:**	
(i)	Norflaxacin	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(ii)	Doxycycline	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(iii)	Parenteral Spectinomycin	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(iv)	Amoxicillin	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(v)	Probencid	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(vi)	Erythromycin Tablets	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(vii)	Erythromycin Syrup	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)

32	**Emergency Contraceptives:**	
(i)	Postinor 2	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(ii)	Eugynon	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(iii)	Neogynon	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(iv)	Microgynon	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(v)	Nordette	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)

33	**Post Exposure Prophylaxis:**	
(i)	Zinovudine	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(ii)	Lamuvidine	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(iii)	Stavudine	Number _____ Expiry date __ / __ / ____ (dd/mm/yyyy)
(iv)	Stavudine Syrup	Amount _____ Expiry date __ / __ / ____ (dd/mm/yyyy)

34 Of those registered with complaints of GBV in the last six months, write the actual number of those who received:

Procedure		Number
(i)	Surgical Intervention	
(ii)	PEP	
(iii)	High Vaginal Swab	
(iv)	Prophylaxis against S.T.I.	
(v)	Tetanus toxoid	
(vi)	Hepatitis B vaccine	
(vii)	Counseling	
(viii)	Follow-up counseling	
(ix)	Emergency Contraception	
(xi)	Referral to a bigger Institution	
(xii)	Advised to report to the police with a P3 form	

Stores

From the stock:

35 Is there at least one month's supply of the items used in the various departments as per the recorded monthly consumption?

(i) Outpatient	[Yes].....[No]
(ii) Laboratory	[Yes].....[No]
(iii) Theatre	[Yes].....[No]
(iv) X-ray	[Yes].....[No]
(v) Pharmacy	[Yes].....[No]

Counseling Department

36 Is there a special counseling room? .... [Yes] [No]

37 Does it offer privacy? ..... [Yes] [No]

38(i) Are there counselors trained specifically for handling GBV? [Yes] [No]

38(ii) If yes, how many? _____

39(i) Do all survivors of GBV get counseling? ..... [Yes] [No]

39(ii) If not all, on average what proportion gets counseling? _____

40 On average, how long does it take a GBV survivor to get counseling after initial treatment? _____

41 On average how many follow up sessions do survivors receive ___

42 Are family members offered counseling? [Yes] [No].

43(i) Are there counselors specifically trained to handle children? [Yes] [No]

43(ii) If yes, how many? _____

44 Do the health workers who handle SV survivors have a support system where they are regularly debriefed? [Yes] [No]

Interviews of Various Heads of Departments

Among the heads of departments to be requested for appointments for interview will include the following departments which are involved in the care of survivors of GBV: outpatient, laboratory, nursing, counseling, gynecology, surgery, pharmacy, registry and

stores. The ideal set up for doing these interviews would be at a round table with all the heads of departments present. These interviews will be audio taped (whenever possible) and transcribed later.

However in a hospital this may not be possible and the recipients may have to fill the questionnaire in their department.

With each department the main points be addressed were:

- Name and department headed.
- Length of time of this member of staff at the institution (In months)
- What are the commonest types of GBV handled in your department?
- What are the main challenges you face in handling the survivors?
- What extra resources or intervention would be appropriate for your department?
- What constraints could you overcome locally?
- Which constraints would need Government intervention?
- What is your general comment on GBV and this community?
- What general trends of GBV are in this community?
- What is the relationship between your department and the non-clinical sectors; police, legal, administration and safe shelter?

Safe Shelter

45 Does the health institution have a safe shelter or association with a safe shelter where the survivors would be accommodated if need be? [Yes] [No]

B. Funding & Budget

This included the cost of stationery, transport, Accommodation and allowances for the enumerators.

The hospitals that were audited and therefore budgeted for were the two National Hospitals, Four Provincial Hospitals, five District Hospitals; Two Faith based hospitals and Nairobi Women's Hospital.

BUDGET				
Particulars	**Daily Rate**	**Days**	**Participants**	**Total**
Fees for research assistants	5000	10	3	150,000
Daily subsistence[food+accomm]	5000	10	4	200,000
Proposal development				15,000
Recruitment and training research assistants		1	3	7,000
Data compilation, report writing and printing.				20,000.
			Total	**KSh392,000**

TRANSPORT

Particulars	**Rates**	**Participants**	**Amount in Kenya shillings**
Kisumu & environs air tickets Kisumu return	13000	2	26,000
Car hire@5000/= day x 4 days			20,000
Fuel Kisumu to Gucha and back			5,000
Fuel Kisumu to Bondo and back			5,000
Fuel Kisumu to Vihiga and back			5,000
Fuel Kisumu airport to Nyanza Hospital and back to airport final day.			3,000
Moi referral hospital & air ticket eldoret return	12,000	3	36,000
Local Taxi To Moi Hospital and back to airport	1500	2	3,000
Air ticket to Mombasa Return	15,000	3	45,000
Local Taxi from airport to hospital and back	1500	2	3,000
Nyeri car hire@ 5,000X1 Day			5,000
Fuel from Nairobi to Nyeri and back			5,000
Fuel Nairobi to Kitui and back			10,000

Nakuru Car hire@ 5000 x 1day			5,000
Fuel Nairobi to Nakuru and back			5,000
Tharaka car hire@ 5,000x 3 days			15,000
Fuel Nairobi to Tharaka and back			15,000
Total Transport Kenya Shillings			**221,000**
Subsistence Supervisors @ 10000 each for 2 days		2	40,000
Total			653,000
GRAND TOTAL			**KSh. 653,000**

For the institutions within Nairobi, the teams commuted by Matatu transport.

The team had accommodation in Kisumu for the four days taken to audit Nyanza and environs, commuting from Kisumu to a specific institution (Vihiga, Gucha, Bondo) and back each day.

Accommodation was required in Kisumu, Tharaka and Kitui.

Other towns (Nairobi, Eldoret, Mombasa, Nyeri, Nakuru) only lunch was required as these were audited and teams returned to Nairobi on same day.

C. List of Tables

Table 2Registered Number of SV Survivors per Institution

Institution	District	Faith Based	Private	Provincial	Referral	Grand Total
1					189	189
2					351	351
3				233		233
4				269		269
5				55		55
6				79		79
7	8					8
8	7					7
9	7					7
10	72					72
11	12					12
12		5				5
13		12				12
14			1404			1404

Table 3: Mandatory Emergency Staff (Medical Officers, Clinical Officers, Gynaecologists and Lab Technologists)

Facility	Type	Survivors	Mandatory Staff	Survivor/Staff	GBVRC
1	Referral	189	218	0.87	Yes
2	Referral	351	214	1.64	Yes
3	Provincial	233	36	6.47	Yes
4	Provincial	269	45	5.98	Yes
5	Provincial	55	20	2.75	No
6	Provincial	79	20	3.95	No
7	District	8	5	1.60	No
8	District	7	8	0.88	No
9	District	7	1	7.00	No
10	District	72	9	8.00	No
11	District	12	7	1.71	No
12	Faith Based	5	6	0.83	No
13	Faith Based	12	0		No
14	Private	1404	28	50.14	Yes

Table 4: Proportion done HVS or RS

Number	HVS and RS
1	0
2	126
3	0
4	190
5	45
6	0
7	0
8	48
9	0
10	0
11	6
12	0
13	4
14	1246

Table 5: Availability of Medicines

	1	2		3		4	5	6		7	8		9		10		11		12		13	14
Drugs	*Solid*	*Solid*	*Syrup*	*Solid*	*Syrup*	*Solid*	*Solid*	*Solid*	*Syrup*	*Solid*	*Solid*	*Syrup*	*Solid*	*Syrup*	*Solid*	*Syrup*	*Solid*	*Syrup*	*Solid*	*Syrup*	*Solid*	*Solid*
Amoxicillin	600	6000		60	1700	1000	4			1000	42000		60	40					13	350	4000	300
Amoxil syrup																100						
Benzathine Pencillin																						
Ceftriaxione																						
Ciproxin										1720												
Doxycycline	4000	1300		5		1000					40000		2		3000		20000		4		3000	1200
Erythromycin Liquid																						
Erythromycin Syrup			300	/								600						100				18
Erythromycin Tablets	48000	2000									12000		2		200				14		4000	500
Falgyl																						2000
Flagyl				15	5000																	
Flagyl metronidazole																						
Norflaxacin	200																		13		100	300
Parenteral Spectinomycin																						
Probencid																					0	
Septrin																						

Table 6: Availability of Erythromycin

STI Marker

Facility	Erythromycin Syrup	Erythromycin Tablets	Syrup	Tablet
1		48000	No	Yes
2	300	2000	Yes	Yes
3			No	No
4			No	No
5			No	No
6			No	No
7			No	No
8	600	12000	Yes	Yes
9		2	No	Yes
10		200	No	Yes
11	100		Yes	No
12		14	No	Yes
13		4000	No	Yes
14	18	500	Yes	Yes

Table 7: Availability of counseling Rooms and Privacy

Facility	Facility type	Counseling room	Offer privacy
1	Referral	Yes	Yes
2	Referral	Yes	No
3	Provincial	Yes	Yes
4	Provincial	Yes	Yes
5	Provincial	Yes	No
6	Provincial	No	No
7	District	Yes	Yes
8	District	No	No
9	District	Yes	Yes
10	District	Yes	Yes
11	District	No	No
12	Faith Based	Yes	Yes
13	Faith Based	No	No
14	Private	Yes	Yes

Table 8: Counseling Staff

		District		Faith Based		Private		Provincial		Referral	Total	Proportion
Facility	GBV complaints	Counselors	Trauma counselors	Counselors	Trauma counselors	Counselors	Trauma counselors	Counselors	Trauma Counselors	Counselors	Trauma counselors	
1	189									5	27	7.00
2	351									9	10	35.10
3	233							13			13	17.92
4	269							5	4		9	29.89
5	55							4	1		5	11.00
6	79							1			1	79.00
7	8	1									1	8.00
8	7	8	2								10	0.70
9	7										0	
10	72	4									4	18.00
11	12	7	4								11	1.09
12	5			5	3						8	0.63
13	12										0	
14	1404					6	3				9	156.00

Table 9: Completed PRC1 Forms

Completed PRC1 Forms	
Facility	PRC1 forms
1	11
2	351
3	
4	222
5	2
6	
7	0
8	0
9	0
10	0
11	2
12	
13	0
14	1404

D Communication Letters

Ethical clearance

KENYATTA NATIONAL HOSPITAL
Hospital Rd along Ngong Rd
P O Box 20723, Nairobi
Tel 726300-9
Fax 725272
Telegrams MEDSUP Nairobi
Email KNHplan@Kenhealthnet.org

15th October 2009

Ref KNH-ERC/A/330

Jane Wakahe
Dept of Community Health
School of Medicine
University of Nairobi

Dear Jane

RESEARCH PROPOSAL: "BASELINE SURVEY OF HOSPITALS PREPAREDNESS TO PROVIDE MEDICAL AND PSYCHOSOCIAL CARE FOR GENDER BASED VIOLENCE SURVIVORS IN SELECTED SITES IN KENYA" (P237/7/2009)

This is to inform you that the Kenyatta National Hospital/UON Ethics and Research Committee has reviewed and **approved** your above revised research proposal for the period 15th October 2009 - 14th October 2010

You will be required to request for a renewal of the approval if you intend to continue with the study beyond the deadline given. Clearance for export of biological specimen must also be obtained from KNH-ERC for each batch

On behalf of the Committee, I wish you fruitful research and look forward to receiving a summary of the research findings upon completion of the study

This information will form part of database that will be [illegible] research study so as to minimize chances of study duplication

Yours sincerely

DR L MUCHIRI
AG SECRETARY, KNH/UON-ERC

c c Prof K.M Bhatt, Chairperson, KNH/UON-ERC
The Deputy Director CS, KNH
The Dean, School of Medicine, UON
The Chairman, Dept. of Community Health, UON
Supervisors Prof J Kimani, Dept. of Community Health, UON
Dr Peter Njoroge, Dept. of Community Health, UON

Permission to Audit the Institutions

MINISTRY OF PUBLIC HEALTH & SANITATION

Telegrams: "FAMHEALTH" Nairobi
Telephone: Nairobi 725105/6/7/8
All correspondence should be addressed to the Head
When replying please quote

DIVISION OF REPRODUCTIVE HEALTH
'ABAGATHI ROAD, OLD
P.O. Box 43319
NAIROBI

10th August, 2009

To whom it may Concern

Dear Sir/Madam,

RE: BASELINE SURVEY ON THE PREPAREDNESS OF HOSPITALS TO DELIVER MEDICAL AND PSYCHOSOCIAL SERVICES TO SURVIVORS OF GENDER BASED VIOLENCE IN HOSPITALS IN KENYA.

The Division for Reproductive Health in conjunction with the German Technical Cooperation (GTZ) intends to conduct a baseline survey to establish the level of preparedness of hospitals in Kenya to deliver medical and psychosocial services to survivors of sexual and gender based violence. The study will inform policy reform, capacity development initiatives and resource allocation requirements that may be necessary in order to address identified gaps.

In order to carry out the research, GTZ will collaborate with the Department of Community Health, University of Nairobi. The Department has identified one of the students who is pursuing her masters in Public Health, Dr. Jane Wakahe to conduct the research under the supervision of her lecturers, Dr. Njoroge and Professor Violet Kimani.
GTZ will provide financial support to Dr. Wakahe to enable her carry out the research.

The research will cover the following hospitals:
Referral hospitals: Kenyatta National Hospital and Moi Teaching and Referral Hospital.
Provincial Hospitals: Nyeri, Rift Valley, Nyanza and Coast
District Hospitals: Bondo, Gucha, Tharaka, Vihiga, Kitui
Faith Based Hospitals: Mutumo Mission hospital, Jamaa Nursing Home, Tigoni, Biafra Clinic.
Private hospital: Nairobi Women's Hospital

The purpose of this letter is to request you to accord Dr. Wakahe the necessary support during her field work.

We thank you for your cooperation.

Yours Sincerely

Dr. B. Kigen
Ag Head, Division for Reproductive Health

Permission to Visit Request

BASELINE SURVEY OF HOSPITALS PREPAREDNESS TO PROVIDE MEDICAL AND PSYCOSOCIAL CARE FOR GENDER BASED VIOLENCE SURVIVORS IN SELECTED SITES IN KENYA.

Chief Administrator,

Dear sir/Madam,

We write requesting permission to visit your institution.

A study is being undertaken by the Ministry of Public Health and Sanitation in collaboration with GTZ on the above topic.

The Department of Community Health, University of Nairobi has been requested to carry out this study, and have appointed me (MPH II) student to collect and analyze data from the various medical institutions. One aspect of gender based violence [Sexual Violence] will be used as part of my thesis. Supervision is being provided by two senior members of staff from the university. There are also three research assistants.

Your institution has been chosen as one of the first fifteen to be visited in this phase. Care will be taken to ensure minimum disruption of the institutions core business of attending to patients, Of special interest are the Outpatient, Pharmacy, Laboratory and Counseling departments all of which will be physically audited. We would also wish to conduct a Focus Group Discussion with the heads of these departments and the nursing aspect to find out their particular challenges in comprehensively managing survivors of GBV.

After collection and analysis of the data, a report will be availed to you.

Our team looks forward to visiting your institution at your earliest convenience.

Please let us know your response soon.

Yours sincerely,

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