

Quality of post rape care given to sexually abused minors
A qualitative study of Homa Bay District Hospital, Homa Bay
County in Western Kenya



By Cynthia Khamala Wangamati

Supervisor: Professor Johanne Sundby

Co-supervisor: Dr. Abdikadir Ali Gele

University of Oslo, Faculty of Medicine

Institute of Health and Society

Department of Community Health

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ABSTRACT

Despite high proportion of minors who have experienced sexual abuse in Kenya are presenting at health facilities for post rape care, literature shows post rape care health services are fragmented and health providers lack confidence in their skills. Thus, this study assesses the quality of post rape care among sexually abused minors in Homa Bay district of Western Kenya. The study examines the health facility's capacity to provide post rape care to sexually abused minors in addition to exploring the perceptions of health care providers on post rape care for survivors of sexual abuse. Accordingly, the study uses triangulation of different qualitative methods such as; review of health records, in-depth interviews as well as observations and case studies. Forty two medical records were reviewed and fifteen health providers and 2 adolescent girls who had been defiled were interviewed. The 2 girls were subsequently followed up as a case study. In addition, observation was used concurrently with the aforementioned data collection methods. The findings show that Homa Bay District Hospital receives an alarming number of sexually abused minors. Despite so, the quality of post rape care in the district hospital is hampered by a lack of medical supplies, drugs and stationery. The health providers had limited knowledge on post rape care and were not conversant with existing guidelines on management of sexual violence in Kenya. Moreover, the staff interviews demonstrated that some of the staff has negative attitudes toward sexually abused minors as well as certain aspects of post rape care. Therefore, the study recommends the development of post rape care delivery algorithms, equipping of the health facility with medical supplies, drugs, stationery and training of health providers on post rape care. In addition, the study proposes sensitization of the community on sexual and gender based violence and collaboration between relevant stakeholders involved in post rape care delivery

DEDICATION

This thesis is dedicated to my family and a special friend: Christy Purvis Stone for all their support, prayers and encouragement.

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ABBREVIATIONS

CDC- Centres for Disease Control and Prevention

CIA (USA) - Central Intelligence Agency (USA)

CIOMS- Council for International Organizations of Medical Science

ECSA-HC- East, Central and Southern African Health Community

E-pills- Emergency contraceptives

HB- Haemoglobin

HIV- Human Immuno-deficiency Virus

HIV nPEP – HIV non occupational Post Exposure Prophylaxis

HVS- High Vaginal Swab

KIPPRA- Kenya Institute for Public Policy Research and Analysis

KNBS- Kenya National Bureau of Statistics

LMP- Last day of Menstrual Period

MOH- Ministry of Health

MOMS & MOPHS- Ministry of Medical Services and Ministry of Public Health and Sanitation

MSF- Medecin Sans Frontieres (Doctors without Borders)

OPD- Out Patient Department

PEP- Post Exposure Prophylaxis

PSC- Patient Support Centre

SGPT/ALT- Liver function tests

STI- Sexually Transmitted Illnesses

UNCRC- The United Nations Convention on the Rights of the Child

UNHCR- United Nations High Commissioner for Refugees

UNICEF- United Nations Children’s Fund

U.S PEPFAR- US President's Emergency Plan for AIDS relief

UTI- Urinary Tract Infections

VDRL- Venereal Disease Research Laboratory

WHO-World Health Organization

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CHAPTER ONE

1.0 Introduction and Literature review

Child sexual violence is common to every culture, society and country of the world (WHO, 2003). Globally, 150 million girls and 73 million boys below the age of 18 years are estimated to have been sexually abused (Pinheiro, 2006). Furthermore, alarming rates of forced sexual debut have been reported in population-based studies conducted in different areas such as Cameroon, the Caribbean, Peru, New Zealand, South Africa and Tanzania. These studies indicate that between 9% and 37% of adolescent females, and between 7% and 30% of adolescent males, have reported sexual coercion at the hands of family members, teachers, boyfriends or strangers (WHO, 2003). A Kenya demographic and health survey carried out in 2008-2009 showed that 12% of Kenyan women report that their sexual debut was forced against their will and 22% of females who become sexually active before age 15 report that their first sexual intercourse was coerced (KNBS, ICF Macr, 2010).

Child sexual abuse is fuelled by a culture of secrecy, stigma and silence which make the abused children likely to report the crime as they are often ashamed, frightened, and incapable of verbalizing their experience (WHO, 2004). As a result, only 10 to 20 percent of child sexual abuse cases are reported to authorities (Pinheiro, 2006). Several reasons have been cited: child sexual abuse is seen as a private matter, especially when the perpetrator is a family member; denial, shame, guilt; fear of social stigma; and lack of awareness of individual rights, what constitutes abuse and when and how to report it (ECSA- HC, 2011). The perpetrator is usually a person known and trusted by the survivors, within or close to the family or has authority over the child (ECSA- HC, 2011).

Given the gravity of negative consequences of physical and psychosocial health consequences of sexual violence, the survivors require immediate access to comprehensive post rape care which include clinical treatment, medical forensic evaluation, HIV non-occupational post-exposure prophylaxis administration. In addition, adherence counselling, emergency contraception, STI prophylaxis and treatment, psychological support and abortion services where these services can be legally procured (Kilonzo et al., 2008; PEPFAR 2013; Kim et al., 2009).

In response to a study conducted in 2003 which revealed poor post rape care delivery in Kenyan Hospitals, the Ministry of Health enacted national guidelines on medical management of

sexual violence in 2004 for guidance purposes (Kilonzo, et al., 2008). The guidelines provide insight on comprehensive post rape care which addresses the medical, psycho-social, legal and humanitarian aspects of sexual violence (MOMS & MOPHS, 2009). Despite the availability of the guidelines, studies show that the health care providers experience challenges when examining children who have been sexually assaulted (Kilonzo, et al., 2008).

Studies conducted in Kenya indicate that a high number of children are presenting at the health facility for post rape care (Speight, et al, 2006, Ranney, et al, 2006). Therefore there is need for comprehensive post rape care which is vital for risk reduction of contracting STIs, HIV infection, unwanted pregnancies and psychological morbidities (Perry, Collins-Willard , & Smock, 2005). However, sexually abused minors seeking post rape care encounter health facilities are ill equipped to offer health care services (Kilonzo et al., 2008). Moreover, studies show that generally, health providers feel uncomfortable and not confident when offering post rape care to children who have been sexually assaulted (Kilonzo et al., 2008). It is therefore imperative to assess the quality of post rape care services that are provided to survivors of child sexual abuse.

The thesis contains four chapters: (1) Introduction and literature review, (2) Methodology, (3) Findings and (4) Discussions, conclusions and recommendations. Chapter one introduces the study and provides a brief summary of what is entailed in the other chapters. It also contains the literature review on child sexual abuse and post rape care given to minors who have experienced sexual abuse. Within the review, child sexual abuse as well as terms related to sexual violence is defined. Global, regional and local prevalence of child sexual abuse is highlighted. Risk factors for child sexual abuse, its consequences, post rape care for minors who have experienced sexual abuse and challenges to provision of care are discussed. In addition, post rape care in Kenya is reviewed.

Chapter two provides an overview of the research design. The theoretical perspective of the research questions is discussed. The chapter also highlights the background of the study site and describes the health facility settings. Data collection methods, data analysis process, reflexivity and ethical considerations are discussed at length in the chapter.

Chapter three is a presentation of the study findings. The findings are presented under four key themes: (1) Quality of post rape care (2) Health facility's capacity to provide post rape care (3) Health providers' knowledge of sexual violence and post rape care and (4) Attitudes of health providers towards components of post rape care and survivors.

Chapter four contains: (1) The discussion of findings, (2) Strengths and limitations of the study and (3) Conclusion and recommendations.

1.1 Literature review

1.1.1 Definitions

According to the World Health Organization, 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 or social taboos of society (WHO, 1999). The abuse may include but is not limited to the inducement or coercion of a child to engage in any unlawful sexual activity; child prostitution or other unlawful sexual practices and promotion or involvement in child pornography (WHO, 1999).

The World Health organization further defines sexual violence as “any act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work” (WHO, 1999). It goes on to state that sexual violence includes rape defined as physically forced or otherwise coerced penetration even if slight of the vulva or anus, using a penis, other body parts or an object (WHO, 1999).

In Kenya, Child sexual abuse has not been stated as a term both in the National guidelines on sexual violence management and the sexual offences Act No 3 of 2006. However, the Sexual Offences Act 2006 outlines in detail child pornography, prostitution, trafficking and sex tourism as offences with penalties. Any person found guilty of promoting child sex tourism or child trafficking or child prostitution is liable upon conviction to imprisonment for a term of not less than ten years and where the accused person is a juristic person (in child trafficking and sex tourism) to a fine of not less than two million shillings (Kenya, 2006). As for child pornography anyone found guilty is liable to imprisonment for a term of not less than six years or to a fine of not less than five hundred thousand shillings or to both and upon subsequent conviction, for imprisonment to a term of not less than seven years without the option of a fine (Kenya, 2006). Furthermore promotion of sexual offences with the child is recognized as an offence:

“A person including a juristic person who (a) manufactures or distributes any article that promotes or is intended to promote a sexual offence with a child; or (b) who supplies or displays to a child any article which is intended to be used in the performance of a sexual act with the intention of encouraging or enabling that child to perform such sexual act, is guilty of an offence and is liable upon conviction to imprisonment for a term of not less than five years and where the accused person is a juristic person to a fine of not less than five hundred thousand shillings ” (Kenya, 2006).

The national guidelines on management of sexual abuse have defined terms related to sexual violence as used in the Kenya sexual Offences ACT. Sexual assault is defined as the partial or complete insertion of the genital organs of a person or an object into the genital organs of another person (MOMS & MOPHS, 2009).

Rape is defined as an act done which causes penetration of one person’s genital organs with the genital organs of another without their consent or where the consent is obtained by force, threats or intimidation of any kind whereas defilement is an act which causes penetration of a child’s genital organs (MOMS & MOPHS, 2009). Penetration has been expounded to mean partial or complete insertion of the genital organs of a person or an object into the genital organs of another person (MOMS & MOPHS, 2009).

Indecent acts which are any unlawful acts which causes (i) any contact between the genital organs of a person, his or her breasts and buttocks with that of another person (ii) exposure or display of any pornographic material to any person against his or her will, but does not include an act that causes penetration have been highlighted (MOMS & MOPHS, 2009).

In addition, incest which is a common form of child sexual abuse has been defined as an indecent act or an act which causes penetration, done by a person to a relative such as a brother, a sister, a mother, a father, an uncle, a cousin or a grandparent (MOMS & MOPHS, 2009).

Under Article 1 of The United Nations Convention on the Rights of the Child, a child means every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier (UNICEF, 2004). That definition is the same as the one used in the Kenya children’s Act 2001 (Kenya, 2007).

1.1.2 Prevalence of Child Sexual Abuse

Sexual debut in many young women is usually characterized by coercion (Garcia-Moreno, et al., 2012). Research suggests that the younger the age of sexual intercourse the higher

the likelihood of forced sexual debut (Garcia-Moreno, et al., 2012). Women divulged that their first sexual intercourse was forced, at rates ranging from less than 1% in Japan to nearly 30% in rural Bangladesh in a study conducted by WHO (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005).

Research has estimated the global prevalence of childhood sexual victimization to be about 27% among girls and around 14% among boys with the average prevalence of reported CSA among females was around 7–8% in studies from South and Central America and the Caribbean, as well as from Indonesia, Sri Lanka and Thailand (Andrews, Corry, Slade, Issakidis, & Swanston, 2004). In parts of Eastern Europe, the Commonwealth of Independent States, the Asia–Pacific region and North Africa estimated prevalence was as high as 28% (Andrews, Corry, Slade, Issakidis, & Swanston, 2004).

Literature review on CSA in sub-Saharan Africa (SSA) affirms that children are at risk of experiencing sexual abuse across different settings including within the home, community and society at large (ECSA- HC, 2011). Moreover, it is proven that child sexual abuse occurs among all ethnic groups (Lalor, 2004 (a)). Despite these findings, research conducted on child sexual abuse in sub Saharan Africa is scanty with the exception of South Africa (Lalor, 2004 (a)). In South Africa, childhood experiences of unwanted sexual touching are reported at rates from 5.2% (Madu, 2001) to 26.3% (Collings , 1997) whereas rates for childhood experiences of abusive sexual intercourse are 7.5% for “rape and attempted rape” (Levett, 1989), 5.8% for “sexual intercourse” (Collings , 1997), 3.86% for “sexual intercourse by force” (Madu, 2001; Madu & Peltzer, 2000), and 4.5% for “oral/anal/vaginal intercourse by force” (Madu, 2001).

Other studies not specific to child sexual abuse but on sexual violence have been conducted in other African countries. A study conducted among 13-15 year old school children in Namibia, Swaziland, Uganda, Zambia, and Zimbabwe on lifetime exposure to sexual violence reported an average of 23% (Brown, et al., 2009). Sexual coercion at sexual debut were reported by 12–19 year old girls in four countries: In Malawi, 38% of those interviewed said they were “not willing at all” at their first sexual experience followed by Ghana (30%), Uganda (23%) and Burkina Faso (15%) (Moore, Awusabo-Asare, Madise, John-Langba, & Kumi-Kyereme, 2007). Additionally, 1 in 3 females (13–24 years) in Swaziland reported to have been exposed to some form of sexual violence in their life (Reza, et al., 2007).

Few child sexual abuse prevalence studies have been conducted in Kenya. According to the findings from the Kenyan violence against children survey, 7% of females aged 18 to 24

reported experiencing physically forced sexual intercourse prior to age 18 (UNICEF, CDC & KNBS, 2012). Twelve months prior to the survey, about 11% of females and 4% of males aged 13 to 17 experienced some type of sexual violence (UNICEF, CDC & KNBS, 2012).

Furthermore, 3 out of every 10 females and nearly two out of every ten males aged 18 to 24 divulged at least one experience of sexual violence prior to age 18 (UNICEF, CDC & KNBS, 2012). The females who had their sexual debut before age 18, 24% reported that they were unwilling (UNICEF, CDC & KNBS, 2012).

1.1.3 Risk factors for child sexual abuse

Predisposing factors for sexual violence fall under three categories: individual factors, parental factors and societal factors.

Individual factors include the age of the child, sex, underage drinking or drug abuse, mental and physical handicap, history of past sexual abuse, psychological and cognitive vulnerability (Berliner & Conte, 1995; Burgess & Holmstrom , 1975; Davies & Jones, 2012).

Parental factors such as poor parenting may result into children being placed under foster care or adoption (Berliner & Conte, 1995; Burgess & Holmstrom , 1975). Moreover, step families, poor parental relationships, negligence and social isolation may increase a child's vulnerability to abuse (Berliner & Conte, 1995; Burgess & Holmstrom , 1975; Finkelhor & Barondo, 1986). Additional susceptibility results from mental health problems and alcohol or drug abuse in parents (Berliner & Conte, 1995; Burgess & Holmstrom , 1975).

Societal factors include weak penalties for perpetrators of sexual violence, high crime rates and conflict in the society and cultural norms that support male dominance and entitlement (Krug, Mercy, Dahlberg, & Zwi, 2002). In addition some social norms justify violence against women for example in some African communities men are not expected to control their sexual desires and therefore the responsibility for male lust is shifted to the girl (Meursing , et al., 1995). Social fictions like beliefs in cure for STIs if one has sexual intercourse with a virgin cure increases susceptibility of girls to sexual abuse in areas with high prevalence of HIV (Meursing , et al., 1995).

1.1.4 Consequences of child sexual abuse

Sexual violence has negative long and short term consequences on children's health outcomes. Short term effects are unwanted pregnancies in girls and sexually transmitted illnesses (STIs) inclusive of HIV. The rate of unwanted pregnancies resulting from sexual assault varies

between contexts and depend on frequency of non- barrier contraceptives usage (Garcia-Moreno, et al., 2012). Pregnant minors are likely to resort to unsafe abortions where abortion is legally restricted (WHO, 2003).

Long terms effects include complications during pregnancy and mental health problems: suicidal thoughts and attempts, clinical depression, post-traumatic stress disorder and behavioural disorders (Reza A. , et al., 2009; Danielson, et al., 2010). Although it is common for children to exhibit sexual behaviours as part of normal development, numerous studies have found that sexually abused children present more sexualized behaviours when compared with other non-abused children (Friedrich, Fisher, & Dittner , 2001; Paolucci, Genuis, & Violato, 2001). A link has also been established between child sexual abuse and violent behaviour (Mullers & Dowling, 2008). Adolescents who have experienced sexual abuse normally tend to vent their feelings through anger and aggression and accept relationships with these elements (Cyr, McDuff, & Wright , 2006). Individuals with a history of sexual abuse are also at increased risk of suicide throughout the life span (Dube, et al., 2001). A study conducted by Sapp & Vandeven (2005) shows that adolescent boys who have experienced sexual abuse are at an increased risk of suicide.

Moreover, research shows that children who have experienced sexual violence tend to abuse alcohol and use illicit drugs in adolescence and adulthood when compared to those with no history of sexual violence (Dube, et al., 2005). The risk is increased due to feelings of helplessness, chaos, and impermanence in children and adolescents who have been sexually abused hence use illicit drugs as a way to escape or dissociate from these feelings (Dube, et al., 2003).

In addition, women who have experienced sexual violence in childhood have a two- to threefold risk of being sexually re-victimized in adulthood compared with women without a history of exposure (Classen, Palesh, & Aggarwal, 2005). Other long term effects include early marriages in girls and children being pulled out of school by guardians or drop out due to fear or depression (U.S PEPFAR, 2013).

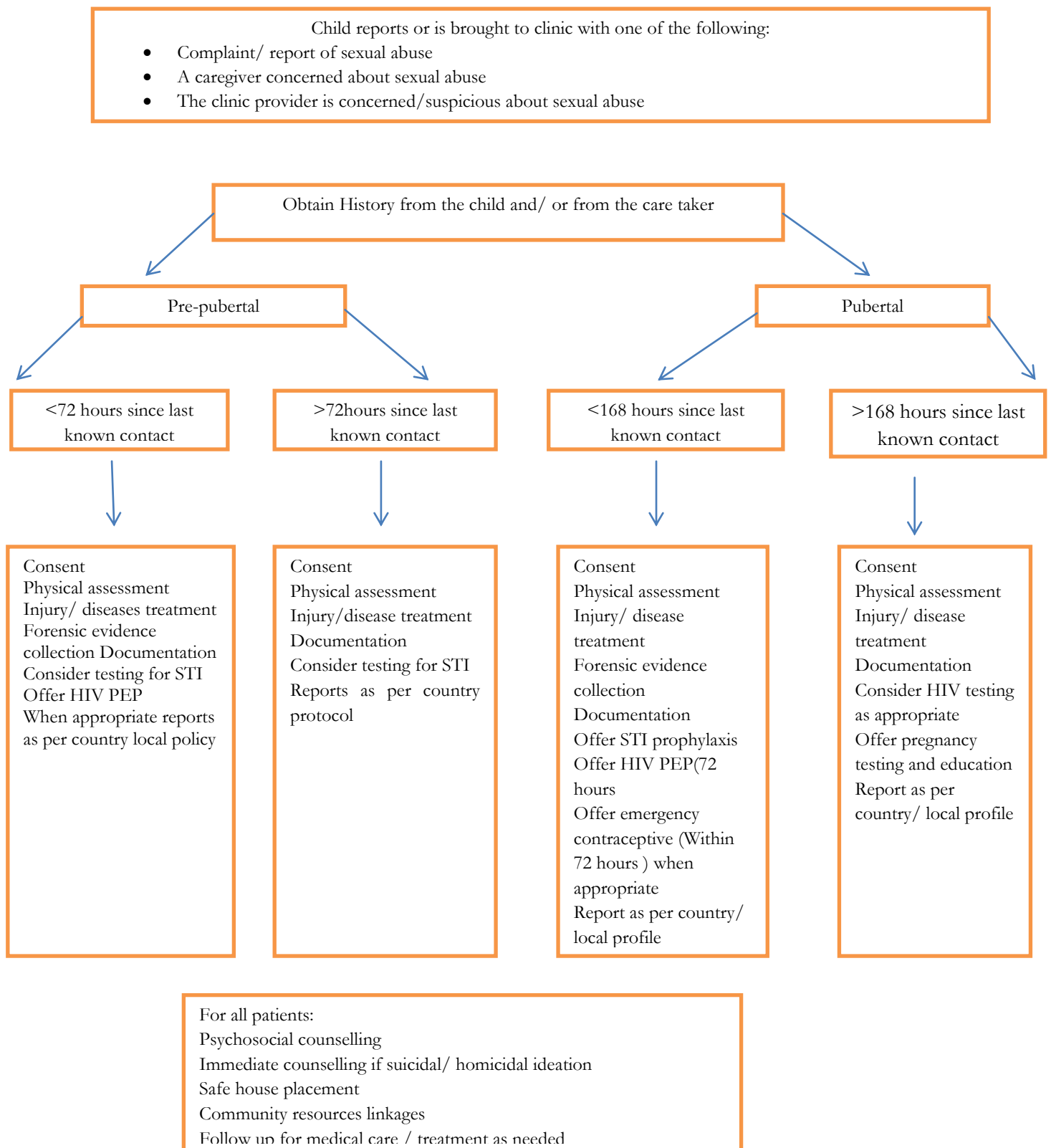
1.1.5 Comprehensive Post Rape Care (PRC)

Survivors of sexual assault require comprehensive, gender-sensitive health services in order to cope with the negative health consequences of their experience (Swart, Gilchrist, Butchart, Seedat, & Martin, 2000). Comprehensive PRC entails clinical treatment, medical forensic evaluation, HIV pre and post-test counselling, non-occupational post-exposure

prophylaxis administration and adherence counselling, emergency contraception, STIs screening, prophylaxis and treatment, psycho social support and abortion services where these services can be legally procured (Kilonzo, et al., 2008; Kim, et al., 2009).

The figure 1 below illustrates the treatment process for minors who have experienced sexual violence.

Figure 1: Post rape care algorithm for child sexual abuse survivors



Source: (U.S PEPFAR, 2013)

For quality post rape care provision, health facilities need to be well equipped to provide services 24 hours a day and 7 days in a week with protocols or guidelines that guide the care provision. The management should ensure that the medical staffs involved in post rape care provision are trained in order to deliver care that is ethical, compassionate, confidential and patient centred. The survivor should be able to feel safe and the settings should also provide privacy (WHO, 2003). In addition, the health sector should collect, store and analyse evidence of the effects of the violence and deliver that evidence to the criminal justice system for purposes of its investigations and use in any trial (WHO, 2003).

The following are minimal requirements for post rape care services health facilities in poor resource settings (WHO/ UNHCR, 2004):

“Personnel

Well trained health care professionals (on call 24 hours a day) if possible male and female at the time of treatment

Setting

- i. Room (private, quiet, accessible, with access to a toilet or latrine)
- ii. Examination bed, a table and chairs
- iii. Light, preferably fixed
- iv. Access to an autoclave to sterilize equipment

Supplies

“Rape Kit” for collection of forensic evidence, including:

- i. Speculums
- ii. Set of replacement clothes
- iii. Tape measure for measuring the size of bruises, lacerations, etc.
- iv. Supplies for universal precautions
- v. Resuscitation equipment for anaphylactic reactions
- vi. Sterile medical instruments (kit) for repair of tears, and suture material
- vii. Needles, syringes
- viii. Gown, cloth, or sheet to cover the survivor during the examination
- ix. Sanitary supplies (pads or local cloths)

Drugs

- i. For treatment of STIs as per country protocol
- ii. Emergency contraceptive pills and/or IUD
- iii. For pain relief (e.g. paracetamol)
- iv. Local anaesthetic for suturing
- v. Antibiotics for wound care

Administrative supplies

- i. Medical Protocols written in language of the provider
- ii. Medical chart with pictograms
- iii. Consent forms
- iv. Information pamphlets for post-rape care (for survivor)
- v. Safe, locked filing space to keep confidential records”

1.1.6 Challenges to provision of Post rape care

Literature on post rape care is limited in Africa and is mostly found in forms of guidelines for treatment. Studies conducted in Sub Saharan Africa on post rape care have discussed it whilst focusing on HIV post exposure prophylaxis (PEP) which is one component of comprehensive PRC. Issues raised are sexual violence and its contribution to HIV transmission in survivors, administration of HIV PEP to survivors and adherence. Non-compliance to HIV PEP medication among sexual abuse survivors has been attributed to logistical reasons, lack of knowledge on medication, individual barriers and social support barriers (Kim, et al., 2009; Abrahams & Jewkes, 2010; Kim, Martin, & Denny, 2003).

Studies conducted on post rape care delivery in health facilities in Africa show an absence of treatment guidelines for care after sexual assault (Kim, Martin, & Denny, 2003; Christofides, et al., 2005; Ellis, Ahmad, & Molyneux, 2005) resulting to substandard clinical care (Kim, et al., 2009). The substandard care is characterized by fragmented service delivery resulting to multiple interactions with health providers and subsequent delays , poor collection of forensic evidence, counselling about drug treatment, trauma counselling, and psychosocial referral (Kim, Martin, & Denny, 2003; Christofides, et al., 2005; Ellis, Ahmad, & Molyneux, 2005; Kim, et al., 2009). Poor collection of forensic evidence is due to inadequate legislation, resources and training (Population Council, 2008). Despite counselling services being key for speeding the recovery process (Campbell & Sefl , 2004; Roland, et al., 2001), they are not well established

(Population Council, 2008). Moreover health providers lack relevant training and have negative attitude towards elements of post rape care (Kim, et al., 2009).

1.1.7 Post rape care services in Kenya

The first research relating to post rape care was a pilot study on post-exposure prophylaxis in Kenya. Findings from the study revealed that there was a high number of paediatric cases presenting at the health facility (Speight , et al., 2006). Health providers experienced difficulties in paediatric dosing using preparations which had been developed for adults at the time (Speight , et al., 2006). Moreover, high default rates were experienced owing to transportation costs and referrals (Speight , et al., 2006).

The second study, a situational analysis on perceptions of rape and post-rape care services was carried out in three Kenyan districts. The objectives of the research were to establish the perceptions of sexual violence in Kenya and to inform the development of a strategy for implementation of post-rape care services in the three district hospitals (Kilonzo, et al., 2008). Findings showed that the gender norms and values shaped susceptibility to, understandings of and responses to sexual violence (Kilonzo, et al., 2008). The incapability of the prospective clients to differentiate between coercive, forced and consensual sex presented challenges for the uptake of post rape care services (Kilonzo, et al., 2008). Moreover, the health providers experienced challenges in discussing sexual violence and supporting survivor communication which led to: insufficient assessment for sexual violence and HIV risk; failure to develop targeted HIV risk-reduction strategies where future occurrences were likely; inability to evaluate and appropriately address the individualised vulnerabilities of survivors and inadequate support for uptake and adherence to PEP (Kilonzo, et al., 2008).

The third study based on findings from the second research. Thence, it described the Kenyan post rape care delivery context. The description indicated that post rape services were limited and survivors were required to meet the costs for drugs and services (Kilonzo, et al., 2009). Policies and protocols on post rape care were lacking (Kilonzo, et al., 2009). Furthermore, there were reports of tensions between HIV and reproductive health staff and the medical examination could only be conducted by doctors (Kilonzo, et al., 2009). There was also an absence of reporting requirements and monitoring and evaluation of services (Kilonzo, et al., 2009).

Therefore, a standard of care was developed for the selected districts and protocols for physical examination, legal documentation and clinical management were drawn to facilitate

delivery of post rape care (Kilonzo, et al., 2009). Health providers were then trained on post rape care: clinical evaluation, risk assessment and legal documentation (Kilonzo, et al., 2009). In addition, HIV counsellors were trained on trauma counselling, HIV testing, PEP adherence and provision of legal information (Kilonzo, et al., 2009).

Initially, all the health facilities under study experienced significant challenges in implementing the new services mainly due to lack of coordination between existing vertical and horizontal systems (Kilonzo et al., 2009). Additionally, the health facilities had poor referral mechanisms in place. Most clinicians self-reported their lack of confidence in regard to testifying in courts of law and were reluctant note-takers (Kilonzo, et al., 2009). On the other hand, counsellors were not sure about shared confidentiality with regard to the rights of the survivor in relation to those of the counsellor to disclose results for medical reasons or when the survivor was a sexually active minor (Kilonzo et al., 2009). Moreover, the lack of a cadre of counsellors in the Kenyan government system hampered service delivery (Kilonzo, et al., 2009). Health providers carrying out doing HIV testing and trauma counselling in addition to their normal duties resulted to provider stress, high attrition rates and inconsistent service delivery (Kilonzo, et al., 2009).

The aforementioned findings were disseminated to the Kenyan Division of Reproductive Health in mid-2004 (Kilonzo, et al., 2009). As a result a committee was constituted and national guidelines for the medical management of rape and sexual violence approved and disseminated in 2005, with a recommendation on user-fees to be waived (Kilonzo, et al., 2009). ‘A universal data form, agreed and approved by the Ministry of Health, became the first clinical form acceptable for legal presentation of sexual violence in a Kenyan court.’ (Kilonzo, et al., 2009).

A fourth study on challenges experienced by service providers in the delivery of medical legal services to survivors of sexual violence was conducted in response to findings from the second study that had indicated concerns over the existing linkages between the criminal justice system and the health care facilities in Kenya (Ajema, Mukoma, Kilonzo, Bwire, & Otvombe, 2011). The objective of the study was to examine some of the obstacles in Kenya to the adequate handling of forensic evidence in sexual violence cases. Results showed that health providers had limited awareness on the various types of sexual offences stipulated in the sexual offences Act (Ajema, Mukoma, Kilonzo, Bwire, & Otvombe, 2011). The health facilities had a shortage of medical doctors to conduct the medical legal examination. Furthermore, specimen collection was

hindered by lack of equipment in the public health facility (Ajema, Mukoma, Kilonzo, Bwire, & Otwombe, 2011).

Since 2005, the Ministry of health has updated the guidelines for the medical management of rape and sexual violence. The guidelines provide guidance on post rape care of sexually abused minors. Information on clinical care, forensic examination and psycho social support has been outlined. To the best of my knowledge no research has been conducted to assess quality of post rape care given to minors who have experienced sexual abuse in Kenyan hospitals as a follow up on how the guidelines are being implemented despite high proportions of paediatric cases (Speight , et al., 2006; Ranney, et al., 2011).

Therefore the aim of the study is to assess the quality of post rape care services given to sexually abused minors.

1.2 Specific objectives

1. To examine the institution's capacity to provide post rape care to sexually abused minors.

2. To explore the perceptions of health care providers on post rape care for survivors of child sexual abuse.

1.3 Research questions

1. How does the health facility provide Post Rape Care services to sexually abused minors?

2. What are the health providers' perceptions on the causes, care and consequences of child sexual abuse?

3. What are the challenges faced by the health care providers when providing post rape care to sexually abused children?

4. How does the health facility network with the other centres involved in post rape care delivery?

CHAPTER TWO

2.0 Methodology

The chapter provides an overview of the research, detailing the study area profile and methods employed in conducting the research. In addition, it outlines the data analysis process, reflexivity and ethical considerations.

2.1 Theoretical perspective

Quality of care is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (Cleary & O'kane, 2013).

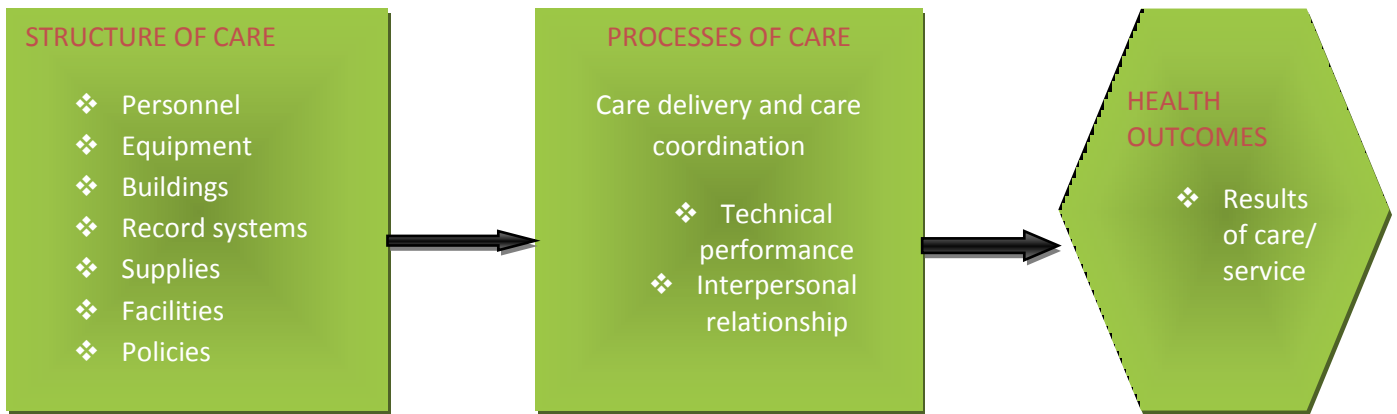
The research borrows from the Donabedian model on assessment of quality of care in order to address the objectives of the study. Malterud metaphorically equates a theoretical framework of reference to an analyst's reading glasses which can be described as theories, models and notions to the interpretation of the material and understanding of a specific institution (Malterud, 2001).

In reference to Donabedian, health care quality can be evaluated by examining the structure (setting) in which care is provided, by measuring processes of care, and/or by assessing what the health care outcomes (Cleary & O'kane, 2013). Structure is the setting in which care takes place and its measures include personnel, health care policies, facilities, equipment, record systems and supplies (Cleary & O'kane, 2013). Process measures assess level of care received by a patient which is determined by the performance of health providers (Cleary & O'kane, 2013). Performance of health providers is appraised with regard to the technical care and interpersonal process whereby judgements on technical quality are subject to the best in current knowledge and technology (Donabedian, 1988). Hence the use of National guidelines for management of sexual violence in Kenya as the yard sticks for measure of standards in the study setting. The aftereffect of processes on the health status and behaviour of patients and populations denotes outcome (Donabedian, 1988).

It is imperative to possess pre-existing knowledge of the linkage between structure and processes, and between processes and outcomes before quality assessment can be performed. Structures of health care provide resources and mechanisms for health providers who carry out patient care activities (McDonald, et al., 2007). The processes are then implemented in order to

improve patient health (outcomes) in terms of promoting recovery, functional restoration, survival and even patient satisfaction (McDonald, et al., 2007). This relationship is illustrated by figure 2.

Figure 2: Donabedian’s quality framework



Source: (McDonald, et al., 2007)

2.2 Study settings

2.2.1 Country Profile

Kenya is located in the Eastern Africa region and extends over an area of 581, 309 km². It lies across the on the coast of the Indian ocean bordering Tanzania, Uganda, South Sudan, Ethiopia and Somalia (CIA (USA), 2014). The capital city of Kenya is Nairobi. Kenya has many ethnic groups that speak different languages. However, the official languages used in communication are Swahili and English. Most Kenyans are religious with 78% identifying themselves as Christians (KPMG, 2014).

Kenya has an estimated population of 43,013, 341 with a high proportion being children under the age of 14 (42.2%) (CIA (USA), 2014). The elderly population (>65 years) account for 2.7% of the population with the remaining 55.1% between 15-64 years (CIA, world fact book, 2014). It is estimated that 49.8% of Kenyans are categorized as poor people (KIPPRA, 2013).

The health care sector in Kenya is underfinanced and heavily dependent on donor aid (KPMG, 2014). It is characterized by poor health services as a result of underfinancing (KPMG, 2014). The situation is exacerbated by inefficient utilization of resources in the health sector,

increasing burden of disease and the rapid population growth rate (KPMG, 2014). Access to medical care is unequally distributed across the country (KPMG, 2014). The rural health facilities are normally understaffed, ill equipped with limited medical supplies (KPMG, 2014). The staffing levels and health financing in Kenya fall below the WHO recommended minimum (KIPPRA, 2013).

Figure 3: Map of Kenya



Source: (Kenya open data, 2014)

2.2.2 Organization of health service delivery in Kenya

The health service system consists of community, primary care, primary referral and tertiary referral services (MOMS & MOPHS, 2012). Community services mostly focus preventive care whereas primary care and referral services deal with curative care and rehabilitative care (MOMS & MOPHS, 2012):

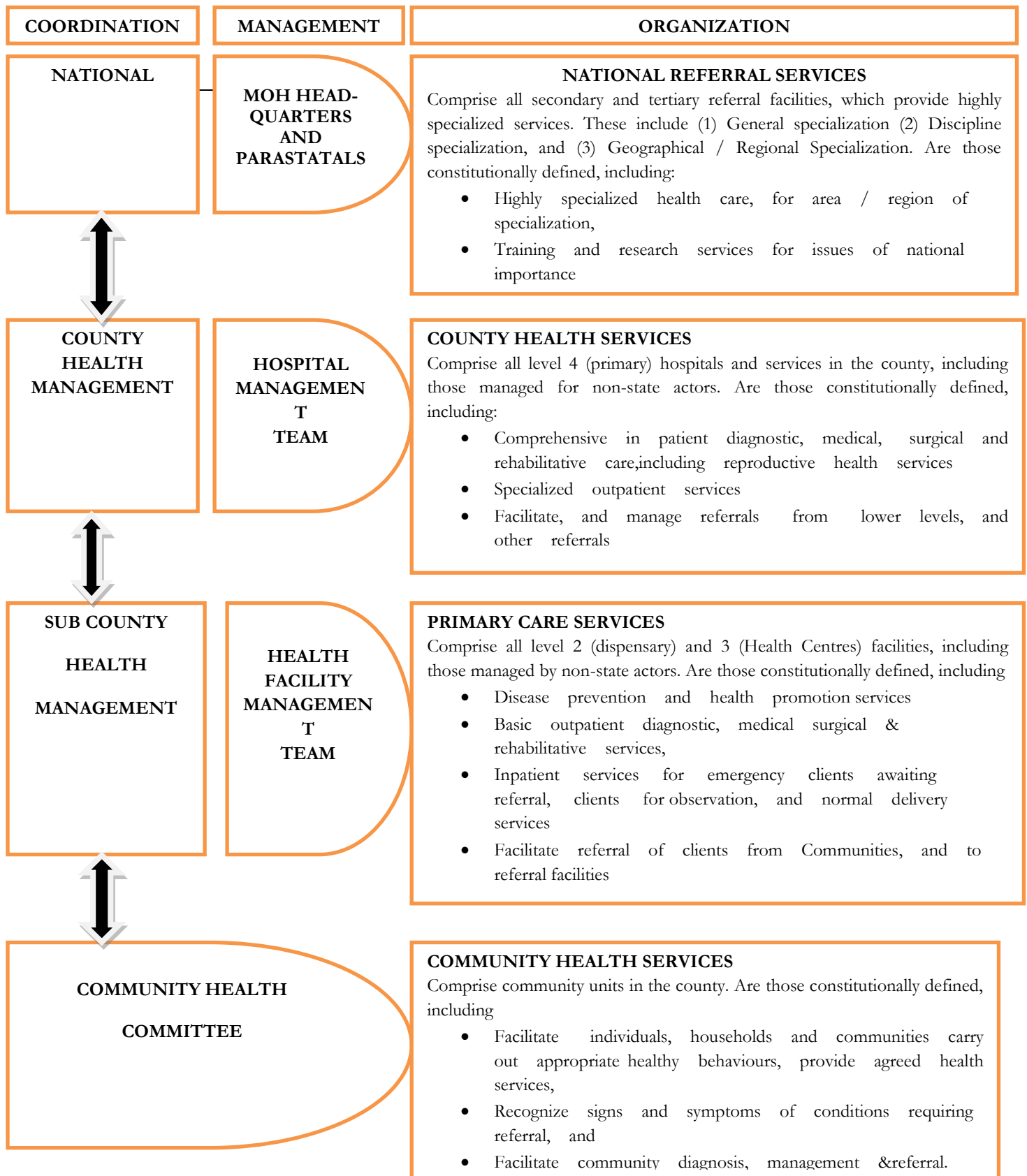
- a. The community services are organized around the Comprehensive Community Strategy.
- b. The primary care services comprise of all dispensaries, health centres and maternity homes of both public and private providers.

c. The county referral services include hospitals operating in, and managed by a given county. This comprises of the former level 4 (Primary hospitals) and district hospitals in the county – government, and private.

d. The national referral services includes the service units providing tertiary / highly specialized services including high level specialist medical care, laboratory support, blood product services, and research. The units comprise of the former Provincial General Hospitals, and national level facilities.

The diagram below gives an overview of the Kenyan Health Service Delivery.

Figure 4: Organization of health services delivery



Source: (MOMS & MOPHS, 2012)

2.2.3 Homa Bay District Hospital

Homa Bay district hospital is located in Homa Bay district which is in the South Western part of Kenya along the shores of Lake Victoria. Homa bay has a catchment population of 204,408. Homa bay district hospital which occupies an area of 15 acres of land has been operational since 1969.

The facility offers preventive, curative and rehabilitation services. Services offered include post rape care, emergency care and first aid, comprehensive care for people living with HIV/AIDs, reproductive, maternal, newborn and child health services. Furthermore, it provides diagnosis and treatment for TB, common illness, physiotherapy, occupational therapy and surgery. In addition, patients access laboratory, X-ray, medical legal services and inpatient facilities.

The health facility is a teaching center for nurses and clinical officers. It also doubles as a training center for medical officer interns, clinical officer interns and other health students on internship. In addition it serves as a referral center for 14 neighbouring districts. It partners with non-governmental organizations that give support in terms of drugs, equipment and staff.

2.3.1 Post rape care services

Post rape care services are offered at the outpatient department (OPD) and the patient support center (PSC). The services are available 24 hours a day, 7 days a week. Although the services are free of charge, in some cases patients incur expenses in the course of treatment. At the OPD, a room had been set aside for examination of patients who have experienced sexual assault. There they undergo a forensic examination for medical legal purposes. Forensic examination is a medical assessment conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion (MOMS & MOPHS, 2009). The designated medical officers (the only health providers allowed by the health facility to conduct the forensic examination) collect evidence from the survivor for juridical purposes. Afterwards the health providers fill in a PRC1 form which is a medical form filled when attending to the survivor and provides space for history taking, documentation and examination (MOMS & MOPHS, 2009). It facilitates filling of the P3 form (A form that is issued at the police station to be filled by a health practitioner or the police surgeon as evidence that an assault has occurred) by ensuring that all relevant details are available and were taken at the first contact of the survivor with a health facility (MOMS & MOPHS, 2009). The survivors are then referred to the PSC after the assessment. However if patients come on weekends i.e. Friday, Saturday and Sunday they are

examined for medical legal purposes, tested for HIV, given emergency contraceptives (pills given to prevent pregnancy in the first few days after intercourse), HIV non-occupational post-exposure prophylaxis (HIVnPEP) for 1-3 days depending and referred to the PSC on Mondays. HIVnPEP for HIV is the administration of a combination of anti-retroviral drugs (ARV's) for 28 days after the exposure to HIV that has to be started within 72 hours after the assault (MOMS & MOPHS, 2009). The same applies for patients who came outside normal working hours i.e. 8.00-5.00 p.m.

At the patient support center, the survivors are taken to the counsellors who offer psycho social support and test them for HIV. Moreover, information is provided to patients depending on their needs on support services available. Afterwards, the patient is sent to the clinician whereby history of the patient is taken. Then the patient is referred to the laboratory for baseline investigations and tests by the clinician. From the laboratory, the clinician prescribes emergency contraceptives, post exposure prophylaxis, STI prophylaxis and PEP for the survivor depending on the age and date of occurrence of the assault. The survivor picks drugs from the pharmacist, gets a Hepatitis B vaccine from the nurse then back to the counsellor who sets up a follow up date. Patients are normally seen on day 1, day 14, day 28 and finally at 3 months by both clinicians and counsellors.

The PSC is run by the Medecin Sans Frontiers in collaboration with the government. It offers HIV care for People Living With HIV/AIDS (PLWHAS). It operated on week days between 8.00-5.00 p.m. In case survivors required admissions, they would be admitted in the Obstetrics and gynaecology ward.

2.3 Study design

The study uses qualitative design with triangulation of methods: review of health records, in depth interviews, observation and case study. In assessing quality of care, the main source of information about process of care and its outcome is the health record (Donabedian, 1988). However, health records especially in developing countries are often incomplete frequently omitting significant elements of technical care with little information about the interpersonal process (Donabedian, 1988). Therefore the inadequacy can be supplemented by interviews with health providers and patients (Donabedian, 1988). Furthermore, if health records are very deficient direct observations can be used even though being observed might elicit an improvement in practice (Royal College of General Practitioners, 1985).

2.3.1 Recruitment of participants

Purposive sampling and snow balling were used to select respondents. For in depth interviews with health providers, respondents were chosen based on their involvement in provision of post rape care. Those at the patient support centre were recruited through the nurse in charge of the patient support centre who requested interviewees to participate in the study on behalf of the researcher. As for the health providers working at the outpatient department and in the wards, contact was made after the review of health records which contained names of the examining health providers. They in turn referred the researcher to other health providers who they thought were resourceful to research.

As for the cases, one was recruited through a counsellor and another through a medical officer in charge of the obstetrics and gynaecology department. Sexual violence is a sensitive topic and therefore there were limited places to access survivors. The intention of the researcher to include cases in data collection was shared with both of them and contacts given out for health providers to get in touch with the researcher whenever a patient arrived.

2.3.2 Review of health records

The review of health records was a suitable method due to their representativeness of routine clinical care making it possible to study real life situations, effectiveness of the health care system and utilization patterns (Bryman, 2012). Health records enable the researcher obtain information at a relatively low cost without delays (Bryman, 2012). However, some of the information recorded in the records is inaccurate because of the errors in diagnostic testing, clinical observation, clinical assessment, recording and coding (Donabedian, 1988).

During the field work, informed consent was sought from the Medical Superintendent to review health records of survivors of sexual abuse. Health records of defiled minors from October 2012 to October 2013 were reviewed retrospectively in the month of November 2013. A research assistant with a diploma in clinical medicine from the Egerton University helped in the review. A total of 42 health records were reviewed. For medical legal purposes, the examining medical officer had to examine the survivor and fill a PRC1 in triplicate and P3 form. These records were kept by a nurse at the outpatient department. Additionally, patients had medical files that were kept at the patient support centre detailing the investigations conducted before administration of post exposure prophylaxis and emergency contraceptives. Thus a complete patient health record comprised of a PRC1 form, P3 form and a medical file.

2.3.3 In-depth interviews

In depth interviews are a conversational partnership whereby the interviewer and the participant are collaborative partners working towards achieving a shared goal of understanding (Rubin & Rubin, 1995). This implies that the interviewer is allowed to seek clarification and ask the participant to elaborate for better understanding yielding a lot of data with great depth. Nonetheless, the large amount of information requires a lot of time allocated for analysis.

Interviews with health providers and defiled minors were conducted from November 2013 to January 2014. A total of 17 in-depth interviews were conducted. Fifteen were with health providers and 2 were with survivors of sexual abuse. Each interview lasted about an hour. Since the health providers had a good understanding of English, their question guides were developed in English. All health providers were interviewed in a private room at the PSC. The interviews were tape recorded and then would later be transcribed verbatim in the evenings.

As for the survivors of sexual abuse, the interviews were conducted in their homes. In all the interviews, the researcher requested permission from the guardians to interview the respondents privately. Swahili language was used for communication purposes because the respondents were primary school pupils and had a good knowledge of Swahili. The interviews were recorded and translated verbatim. Further in depth discussion of these interviews is under case studies.

As a result of different professions and roles played by health providers, the thematic guides were tailored to their roles. The researcher used one semi structured thematic to interview the nurses, clinicians and medical officers. One theme was on the understanding of health providers of relevant terms used in post rape care as per the national guidelines on management of sexual violence in Kenya and the sexual Offences Act 2006. Perceptions of health providers on the causes and consequences of child sexual abuse were part of the subject matter. Other topics were on post rape care administration, skills, training, referral, challenges experienced and institutional support.

A semi structured thematic guide tailored to the practice of counsellors was used in their interviews. The themes included understanding of terms as used in the national guidelines on management of sexual violence and the Sexual Offences Act 2006. Additional topics were on counselling, referrals, supervision, therapy and institutional support.

The pharmacists' guide covered areas on understanding of relevant terms used in post rape care as per the national guidelines on management of sexual violence in Kenya and the sexual Offences Act 2006. Perceptions of health providers on the causes and consequences of child sexual abuse also included as a theme. More topics on skills, training, pharmaceutical management, challenges experienced and institutional support were included.

The guide administered to the lab technologist touched on understanding of relevant terms used in post rape care as per the national guidelines on management of sexual violence in Kenya and the sexual Offences Act 2006. Perceptions of health providers on the causes and consequences of child sexual abuse were also included as a topic. Additional themes were on skills and training, laboratory work, challenges experienced and institutional support.

The thematic guide for health records officer focussed on his understanding of the relevant terms used in post rape care as per the national guidelines on management of sexual violence in Kenya and the sexual Offences Act 2006. Other issues included data management, skills, training, challenges experienced and institutional support.

The table below shows a list of interviewed health providers.

Table 1: List of Interviewees

No.	Sex	Profession	Education	Department	Employer
1	Female	Nurse	Diploma in Nursing	Outpatient Department	Government
2	Male	Clinical officer	Diploma in Clinical medicine	Patient Support Centre	Government
3	Male	Clinical officer	Diploma in Clinical medicine	Patient Support Centre	MSF
4	Female	Nurse	Diploma in Nursing	Patient Support Centre	MSF
5	Female	Medical Officer	MBCHB	General ward	Government
6	Female	Clinical officer	Diploma in Clinical medicine	Patient Support Centre	MSF
7	Male	Medical officer	MBCHB	General ward	Government
8	Female	Nurse	Diploma in Community Health Nurse	Outpatient Department	Government
9	Female	Pharmaceutical technologist	Diploma in Pharmacy	Patient Support Centre	MSF
10	Male	Health records officer	Certificate in Health records and Information technology	Health records Office	Government
11	Female	Counselling Psychologist	Masters in Counselling Psychology	Patient Support Centre	MSF
12	Male	Laboratory technologist	Diploma in Medical Laboratory Sciences	Laboratory	Government
13	Male	Medical officer	MBCHB	Obstetrics and Gynaecology ward	Government
14	Male	Pharmacist	Bachelor in Pharmacy	Patient Support Centre	Government
15	Female	Psycho social counsellor	Kenya Secondary School Education	Patient Support Centre	MSF

2.3.4 Case study

This is a qualitative approach in which the investigator explores a case or cases overtime through detailed, in depth data collection involving various sources of information (observation, interviews, audio visual material and documents) and provide a case description and case based studies (Yin, 2003). Hence the researcher is able to detail the context of the study. However, the use of many methods yields a great depth of data that is time consuming during analysis.

Using several sources of information two cases were followed extensively. The first case was of a 14 year old girl named Christine (pseudonym) whom the researcher met on day 14 of her treatment. Informed assent and consent were sought from her and the guardian respectively. The information on the consent forms was read out aloud. Through the information, respondents were assured of confidentiality and informed that their participation was voluntary. More assurances were made on the fact that their participation in the study would not interfere with their medical treatment. The participants were also allowed to raise any concerns before the start of the interviews. The first interview was conducted at the respondent's home whereby the researcher requested for privacy from the respondent's family members in order to avoid any interference. Subsequently, it was followed up by review of her medical files. Another interview was conducted at the health facility in a private room after the participant's follow up visit. Later the researcher held informal conversations with the police regarding her case in order to find out progress made on the case.

The second case was a girl of 14 years named Edna (pseudonym) whom the researcher met on her first day of treatment. I recruited her through a medical officer who was in charge of the obstetrics and gynaecology department. Informed assent and verbal consent was sought from her and the acting guardian respectively so that the researcher could observe her treatment process. The researcher shared with them the research objectives and assurances were made to the effect that the information obtained would be kept confidential and would not affect the treatment process in any way. Additionally, the researcher made clear that their participation was voluntary and they could withdraw any time. Informal discussions with the respondent, her guardian and examining medical officer were carried out before and after the treatment process.

The next day, the researcher visited Edna's family where assent and informed consent was sought. The information on the consent form was read out aloud. Through the information, they were assured of confidentiality and informed that their participation was voluntary. More assurances were made on the fact that their participation in the study would not interfere with the medical treatment. The researcher allowed the participants to raise any concerns before the start of the interviews. An interview with Edna was conducted after asking for privacy from her family members. After the interview, informal discussions with the parents on their feelings and plans regarding the defilement were held. Further follow up was made through phone calls. In addition, informal conversations were held with police officers who played a key role in defilement cases.

2.3.5 Observation

Structured and direct observation was used in the data collection. Direct observation is a great technique for examination of client provider interactions (Campbell, Collumbien, & Southwick, 1999). Observations enable the researcher to relate what is being said to actions and give a description of the settings hence creating context for the reader. Even so, it requires great skill in terms of awareness to pick up the nonverbal communication and what is happening in the surroundings.

The researcher sought informed consent from the medical superintendent in order to access to areas serving sexually abused minors within the health facility. Observations on interactions between survivors of sexual abuse and the health providers both at the OPD and the PSC were noted. Usually, the researcher took mental notes on the environment, interactions within the environment, information sharing and the effect of the interactions on adherence or non-adherence to the treatment. Later, mental notes would be transferred into the note book at the researcher's discretion during breaks.

Structured observation was conducted by the help of a checklist i.e. the WHO provision of medical and forensic services to survivors of sexual violence equipment list. Both the researcher and the research assistant did a health facility inventory of medical equipment and drugs available for provision of post rape care. Observation was used concurrently with other methods.

2.4 Data analysis

The analytical process begun in the field during the data collection and as gathered data was analysed it shaped the ongoing data collection process (Kielmann, Cataldo , & Seeley, 2011).

For health records, most of the analysis was done in the field. The researcher and research assistant categorized the records into those of medical legal importance (P3 and PRC1 forms) and medical files (detailing preliminary baseline investigations before PEP, PEP, emergency contraceptives, STI prophylaxis and vaccinations). As the review progressed, clarifications were sought from health providers on areas not understood and explanations on mode of operation. The health records gave the researcher a better understanding of the medical procedures which was resourceful in interviewing.

The interviews were recorded and transcribed in the evenings. During the transcription, the researcher would try to figure out what was missed out and if responses given answered

research questions. Then, the researcher would put down questions that needed clarifications which were sought through informal conversations. In addition field notes (obtained from observations, informal conversations and interviews) were reviewed to ensure that they gave context to the research and for the researcher to get an overall view of the preliminary findings.

Data triangulation i.e. reviews of health records, use of case studies, in depth interviews and interviews improved validity. The methods complemented each other and helped the researcher gain a better understanding of the data.

Afterwards, the researcher read and re read the transcripts and field notes several times to familiarize and understand the data in order to derive meaning (Malterud, 1993). The material was then coded into 40 categories. The 40 were iteratively merged into 20 then 8 and later 4 themes. These themes are supported by theoretical explanation in the discussion. The themes were developed both deductively and inductively and are supported by theoretical explanation in the discussion.

2.5 Reflexivity

A researcher's background and position affects what they choose to investigate, the angle of investigation, the methods judged most adequate for the study, the findings considered most appropriate, and the framing and communication of conclusions (Malterud, 2001).

The topic was chosen as a result of my work experience in a humanitarian organization. Most times, I encountered difficulties in accessing and getting quality post rape care for survivors in the health facilities. This propelled me towards seeking a solution to making post rape care accessible to survivors of sexual abuse. Notwithstanding, I am aware that my thesis would not provide a solution on its own but will contribute to the evidence base for the determinants (barriers and enablers) of post rape care in resource limited settings.

After getting ethics approval, I began my data collection at the health facility. First, I started reviewing health records with the help of my research assistant. The review helped me to gain an understanding of how the health system functioned, the treatment and referral process.

My passion about the researcher grew with each day I was in the field. The reason being, I met some survivors e.g. 5 year olds and felt like they deserved the best treatment. They had a future ahead of them and the treatment process would either make or break them. This passion made it a bit hard for me to conduct my 3rd in depth interview. The clinician thought some survivors were to blame for the sexual abuse. According to him indecency was a cause of rape.

For that particular interview I struggled to keep a straight face. To be objective, I focussed on his truth and was grateful for his honesty.

Moreover, I felt a great ton of responsibility over my cases. I often thought about their challenges. As a result, I purchased emergency contraceptives for one of them because the ones in the hospital were out of stock. The participants in my case studies would refer to me as a doctor. This was due to the fact that they were referred to me by the counsellor who didn't have an equivalent word for a researcher in the local dholuo language. Every health practitioner was referred to me as 'daktari' despite their different professions and roles. However, I always explained about my research and told them I wasn't a doctor. I would explain that my role was to see if they were being well taken care of and whatever was told to me was a secret. I felt that my presence in their homes made me a 'different doctor'. Being aware of this fact, I would always open discussions and interviews with topics on family, neighbours and school.

2.6 Ethical considerations

Research involving human subjects should be conducted in accordance with basic ethical principles: respect for persons, non-maleficence, beneficence and justice (CIOMS, 2002).

2.6.1 Ethics approval in Norway and Kenya

The study was approved by the Norwegian regional committee for Medical and health research ethics. Ethics approval was sought from the Kenyatta University Ethics Review Committee in Kenya. This paved way for issuance of a research permit from the National Commission for Science and Technology in Kenya. The approval and permit allowed me to gain approval from the county government, the county education office and the Homabay District Hospital in order to commence the research.

2.6.2 Informed consent

Respect for autonomy and protection of vulnerable persons was ensured through elaborate explanations of the study objectives and emphasis on voluntary participation (Ellsberg & Heise, 2005).

During a presentation of the protocol before the Homa Bay District Hospital health advisory committee, they were informed of need for approval and consent for review health records. They were also made aware about observation as data collection method and consent was sought for its use. Verbal consent was granted for these data collection methods.

Before interviews with health providers, I shared information about the study and additional information relating to their participation as outlined in the consent form. Time was allocated for them to read through the consent form and ask questions. The form (written in English) informed them about the study, its aims and objectives. It talked about confidentiality, voluntary participation and withdrawal from participation at any time without giving reason.

Before recruitment of my cases verbal and written consent were obtained from the guardians. Assent was obtained from the adolescents. The consent forms were in Swahili, Kenya's national language which was well understood. They addressed confidentiality, voluntary participation and withdrawal at any time without reason. Assurances were also made to the effect that information provided would not in any way affect their treatment as it was confidential.

2.6.3 Anonymity of research participants

Anonymity for interviews was maintained by giving interviewees numbers instead of using their names on the thematic guides and transcripts. A list of numbers matching with their names was kept at my house in a cabinet under lock and key. I also made sure that the recording began after the introductions. As for the cases, pseudonyms were used for reference of participants and place of residence. For the health records, numbers were allocated to the patient names to make the information anonymous when data was shared.

2.6.4 Data storage and handling

During the review of health records, only the research assistant and I had access to the health records. At breaks and in the evenings, the files were kept in a lockable cabinet by a counsellor who was in charge of safeguarding the health records. Information obtained from health records, recordings and filed notes were transcribed into my computer and protected by a password known to me and my research assistant. A list which contained names and numbers of respondents, completed guides and notes books were kept under lock and key in a cabinet in my house. All materials related to research will be destroyed after completion of my masters.

2.6.5 Ethical dilemmas

I am aware that the research process should not be interfered with. However, at times I felt obligated and helped out some of my cases. One instance was when during the medical examination of Edna where gloves were out of stock and she did not have money to buy them. She lay on the examination table naked for a period of time while the nurse went to look for gloves from a colleague. She also missed out on contraceptives as they were out of stock. Her

parents could not afford the contraceptives which I bought for her. In my opinion, research participants should be able to benefit from the research and hence my assistance to Edna.

CHAPTER THREE

3.0 Findings

Four key themes emerged from the data collected/ field notes:

i. Quality of post rape care

The theme highlights the processes involved in offering care to minors who have experienced sexual abuse with focus on technical performance of health providers.

ii. Health facility's capacity to provide post rape care

The topic presents limitations that are existent within the facility's structures that hinder delivery of care.

iii. Health providers' knowledge on sexual violence and post rape care.

Findings on the knowledge of health providers in comparison with the current knowledge on post rape care in Kenya are presented under this theme.

iv. Attitudes of health providers towards components of post rape care and survivors

Insight is given on the perceptions of health providers on elements of PRC.

The themes and sub themes with illustrative examples are presented below.

3.1 Quality of post rape care

3.1.1 A case study of post rape care of a defiled minor

I met Edna (pseudonym) a girl of 14 years when she sought post rape care at the health facility. She was accompanied by a female police officer and a young lady. I introduced myself and my research assistant and told them about my research. Thereafter, I sought verbal consent from the police officer and assent from Edna so that I could recruit her as my case. Both of them consented. I sought consent from the police officer because at the time Edna was unaccompanied by her guardians. Moreover, I requested for her guardian's number, phoned and let her know about the recruitment. As a result of the phone call, she agreed that we meet the following day for an interview.

Edna had already been tested for HIV by a female nurse and given a start dose of antiretroviral drugs (ARVs) for post exposure prophylaxis (PEP) for 3 days as she had arrived on the weekend. Usually the Medecins Sans Frontiers (MSF) clinic would give PEP to all survivors of sexual violence. This is because it supported the health facility in terms of HIV/AIDS care provision. However, it only operated on weekdays between 8.00a.m.-5.00 p.m. as it was a non-governmental organization. Therefore, she was requested to go back on Monday for continuation of PEP. Additionally, she had been given a prescription to buy emergency contraceptives as they were out of stock.

The five of us waited for the medical officer, who had been asked to conduct the medical legal examination for about one and a half hours. The nurse had phoned him earlier and said he was on his way. As we waited, I asked Edna about her family. She informed me that she came from a family of 8 and they lived in Rabouri (pseudonym). She had paid Kshs.50 as transportation fee to the police station. At the police station, she recorded a statement in regard to what had happened. After that, she had been told to accompany the police officer to the hospital for treatment. At the facility, the nurse had given her medication to prevent HIV and a prescription to buy drugs for preventing pregnancy.

The medical officer finally came in, looking a bit irritated and asked loudly for the girl who had been raped. Edna stood up and followed him to the examination room. The police woman, my research assistant and I followed suit. I introduced myself and informed him about my research. After the intro, he asked Edna about her ordeal. Edna narrated how she had woken about at around 11 p.m. to relieve herself outside. As she came back from the latrine, a man (high school teacher) who was their neighbour intercepted her started pulling her towards a nearby maize plantation. She resisted and tried to scream. The man responded by slapping her hard and threatened to kill her if she tried to scream. He then dragged her into the maize plantation and defiled her.

The medical officer asked her if she had changed her clothing and taken a bath. Her response was negative. He also asked her to stand up and turn around. He then asked her to undress behind a curtain that separated the room and lie on the bed so that he could examine her. During the examination, the medical officer realized he didn't have gloves and went out of the room to look for a nurse to give him gloves. The nurse's response was that the gloves were out of stock. She came in and asked Edna if she had money to buy gloves. Edna told her that she had no money. The nurse decided to go and look for her colleague to see if she had any extra

gloves. In that event, I offered to buy the gloves considering the girl was lying naked on the examination bed and the nurse was gone.

With the gloves on, the medical officer proceeded to examine her, looking for any marks on her hands and body. He instructed her to put her legs in a frog leg position so that he could examine her genitalia. Realizing he had no lubricant, the medical officer rushed to the next room to get it. In the meantime, Edna felt shy and covered her face as she was naked. The medical officer came back and proceeded to examine her genitalia. The officer seemed to have trouble seeing and my research assistant suggested he gets some source of light. The fluorescent tube on the ceiling was not working. He first asked if any of us had a phone that has a small torch. Unfortunately none of us had it. Fortunately, his phone had a source of lighting which my research assistant directed towards the girl's genitalia to enable him conduct the examination. From his observation, the medical officer concluded that there were no lacerations but my research assistant (a trained clinical officer) pointed out to him that the girl's inner thigh had lacerations. He then noted them and concluded the examination.

As the medical officer filled the PRC1 and P3 form, my research assistant informed me that the medical officer had used an adult speculum to examine the girl. Despite conducting the speculum exam no specimens had been collected. The medical officer handed the completed forms to the police officer and Edna who left. I remained behind to inquire the reasons as to why he didn't collect any samples. He responded by stating that it wasn't his job. According to him, the responsibility of collecting samples lay with the laboratory technician who was not present.

The following Monday, Edna went back to the police station and recorded another statement. The recording of the statement took a long time such that by the time she went to the MSF clinic the clinicians had left. Luckily, she met the counsellor who counselled her about PEP adherence. The counsellor then requested the pharmacist to give her medication for the day. Edna was given the medication and requested to come back and see a clinician on the following day of which she did not turn up. As a result, I phoned her grandmother and requested that she asks her to come on Wednesday. She never did. I phoned her grandmother again to find out what happened. Her response was that she thought Edna had spent the night at my place. Consequently, she concluded that Edna had disappeared.

Later on I met one of the police officers dealing with Edna's case who informed that he thought it would be solved at home. According to the information he had received, a group of

people were sent by the perpetrator to her grandfather. They were negotiating on an agreement whereby the perpetrator would pay some money to Edna's grandfather. Apparently, this was a common occurrence in many defilement cases.

I made inquiries in regard to collection of samples from survivors of defilement from the medical officer in charge of the obstetrics and gynaecology ward. He told me that it was the responsibility of the examining medical officer. I learnt that the medical officer who had examined Edna was quite new and therefore lacked experience in forensic examination.

3.1.2 Forensic examination

The Kenya guidelines on management of sexual violence state that specimens to be collected from survivors should include: swabs (mouth, vaginal, anal and oral), urine of both the survivor and suspect, pubic and head hair, foreign fibres, grass or soil, liquid blood, fingernail scrapping or clippings, blood stained clothes and bite marks. In spite of the recommendations, the examining medical officers only mentioned semen (HVS), blood (HIV test), pubic hair and status of clothing as reflected in the following excerpts:

".....we examine these patients, we want to look if the patient struggled, so we look at any marks, was the patient beaten, then we proceed to (pause). As I've said most of the victims that we get are girls, I have never got a case of a boy who has been defiled. We normally do vaginal examination look whether there are tears or no tears, we check whether there's semen or no semen, any discharge, then we take samples, we do a high vaginal swab (HVS), we take any external discharge that we might see is taken for further examination and for further tests. HVS we don't do it under anaesthesia we only insert the speculum and do the HVS....." (Government medical officer)

"Basically we do a physical examination, head to toe, what you see, their status, the clothing and after that you do a detailed genital examination where you check the vagina and anus... you know the whole genitalia. (Interviewer: samples taken?) We take a HVS for spermatozoa and basically the HIV test. (Interviewer: when do you do HVS?) When the patient has a vaginal penetration and there was no use of a condom. We sometimes do a urinalysis it depends with what you find and what the patient reports for. If the patient has got some infections ...depends on what the patient reports. We check if the patient has had any tears or lacerations that can be repaired, its also for medical legal purposes." (Government medical officer)

In most cases, when examining children a speculum exam is not indicated as per the guidelines. It is only indicated when the child may have internal bleeding arising from a vaginal

injury as a result of penetration. In such a case, a speculum examination should be done under general anaesthesia. Nonetheless, the health providers were not conversant with the circumstances under which HVS should be performed from the explanation:

“ We start with specimen samples that we took for semen and if there was any sample of stains on the cloths maybe we can send specimen to forensics, and then we take some sample of pubic hair of the patient, if there were any scratches, or any tears or any wounds we can take that into consideration as well. (Probe- HVS for children?) HVS depends...if the child was sexually active we do...if not we don't do that. (Probe-Is it done under general anaesthesia?) We don't do under anaesthesia just normal.” (Government medical officer)

For survivors to be able to obtain justice through the juridical system, it's imperative that the police work towards collecting evidence and presenting it to the courts. Health care providers said that the police brought the survivors to the health centre to seek health services:

“Usually they (survivors) come with a police officer who is usually present at the time, and when they come in we have forms, if they come with a police officer there is a P3 form which we fill for purposes medical legal reasons.” (Government medical officer)

Their only reservation was that despite them seeing defilement cases regularly, they were rarely called to court to give evidence. A government medical officer said:

‘...the only thing I can say is these cases take too long... sometimes you have handled so many cases and you have never even been called to court yet you fill these forms on a daily basis, you're seeing 3-4 cases a week.. you only attend like I've said I've only attended court once...probably from the police side like these cases they drag them and these victims never get justice.’ (Government medical officer)

Through informal conversations, I found out that the police cases took long because majority of the caregivers opted to solve defilement cases at home. The perpetrators would pay a fine to guardians who would then withdraw from the juridical process. There were also allegations of bribery at the police department; some health providers felt that if the perpetrator bribed the police then court files would disappear mysteriously never to be found.

3.1.3 Psycho social support

After the forensic examination, patients would be referred to the patient support centre for the psycho social support and medical treatment.

Three types of counselling should be offered as stipulated in the national guidelines on management of sexual violence in Kenya. These include trauma counselling, counselling related to possibility of a pregnancy and counselling related to possible STIs including HIV infection. MSF clinic only offered HIV pre and post-test counselling and adherence counselling. Counsellors seemed to have limited capacity in trauma counselling as reflected in the statement below:

“On the first visit when they come sometimes the child may not be able to talk much, but maybe during follow up when they come back on day 14 and then maybe you can find how to go about it. So what we do because you know on this day the child is still very traumatized and you cannot subject them to talking so if they cannot we just leave, so if there’s an issue if they come back on the next visit then we probe again.” (MSF psycho social counsellor)

The guidelines also recommend that for trauma counselling, there should be a minimum five sessions. However, the minimum number of counselling sessions was three as told by the MSF counselling psychologist:

“3 counselling sessions. First day of contact. That day is the day the report is being made. Then (pause) if the person qualifies for PEP, the first point is the time for getting the story. What happened, the emotional status of a person. We do a HIV test, if negative they qualify for PEP. So we take them through the medication they’re going to be given, possible side effects and management and all that. Day 14 after initiating PEP they have to come back. That’s just to find out how are you going on in terms of side effects, any missed pills, encouragement. Then Day 28 upon finishing PEP there’s the second HIV test to confirm if they are negative or positive. Then after that we tell them they can come back again 3 months here for another confirmatory HIV test or wherever it’ll find them.” (MSF counselling psychologist)

After the counselling session, the counsellor referred the survivor to appropriate qualified professionals based on the needs of the patient. The counsellors provided the patient together with the caregiver emotional support and information that they might have lacked or

they deemed useful for them. They would also prepare both the guardian and the child on what to expect as they go to see the clinician:

“Largely offering emotional support first, aside from emotional support also offering information. Because a survivor could come yes I have been raped but I don’t exactly know what aside from wanting to tell to someone, I don’t know exactly what to do next. Providing information such that you could report it to the police, these are medical services that can be offered in terms of vaccination some form of care to prevent certain STIs or even transmission of HIV. So emotional support and providing information and linking the survivor to someone who could assist them more.” (MSF counselling psychologist)

The counsellors were not aware of the legal procedures and proceedings after reporting sexual assault incidents. However, they informed the caregivers on the importance of reporting the sexual assault to the police stations.

3.1.4 Medical care

Mostly, the medical care was provided by clinicians and nurses. During medical examination of a survivor basic investigations on assessment of the patient’s general condition should be conducted as per the Kenya national guidelines on management of sexual violence. These include urine specimens and blood tests. The urine tests comprise of urinalysis (Microscopy) and pregnancy test. The blood tests include the HIV test, haemoglobin level, Liver Function Tests and Venereal Disease Research Laboratory test (VDRL). Baseline haemoglobin should be taken within 3 days of starting PEP, and ideally be repeated at 2 weeks, because of the potential for ARV induced bone marrow suppression. Ideally SGPT/ALT (liver function) and Creatinine should also be checked at baseline and the SGPT repeated at 2 weeks.

However, the review of 15 medical files at the patient support centre showed that the baseline investigations weren’t always done. Only 2 out of 15 patients had their baseline haemoglobin taken. Creatinine and liver function was not checked for almost half of the patients seen. Nine out of fifteen patients were tested for HIV and none for sexually transmitted illnesses (VDRL).

Furthermore, emergency contraceptive pills (E-pills) are meant to be dispensed to post pubescent girls to prevent pregnancy as per the guidelines yet only half of the eligible patients were given the pills. Before dispensing the E- pills, the patient should be tested for pregnancy. Despite the recommendations only 3 of the 8 adolescents were tested. The records also showed

that majority of the patients were given the hepatitis B vaccine as stated in the guidelines. In contrast, no records showed the issuance of tetanus vaccine which is also a requirement in case of injuries. The table below illustrates the type of investigations conducted, drugs, vaccinations given, the rate of adherence for patients at 2weeks and subsequent 4 weeks, 3 and 6 months.

Table 2 : Medical files of defiled Patients at the Patient support centre (MSF clinic)

Variable			Proportion	Total (%)
Age		4-7	3/15	(20)
		8-11	4/15	(26.7)
		12-15	8/15	(53.3)
Management	STI Management	Yes	12/15	(80)
		No	3/15	(20)
	PEP	Yes	15/15	(100)
		No	0/15	(0)
	Vaccines	Yes	14/15	(93.3)
		No	1/15	(6.7)
	E Pill	Yes	4/8	(50)
		No	4/8	(50)
Investigations	HB	Yes	2/15	(13.3)
		No	13/15	(86.7)
	Liver Fn Tests	Yes	6/15	(40)
		No	9/15	(60)
	Creatinine	Yes	8/15	(53.3)
		No	7/15	(46.7)
	Urinalysis	Yes	1/15	(6.7)
		No	14/15	(93.3)
	VDRL	Yes	0/15	(0)
No		15/15	(100)	
HIV Test	Yes	9/15	(60)	
	No	6/15	(40)	
LMP	Yes	4/8	(50)	
	No	4/8	(50)	
Pregnancy Test	Yes	3/8	(37.5)	
	No	5/8	(62.5)	
Follow-up	2 Weeks	Yes	6/15	(40)
		No	9/15	(60)
	4th Week, 3rd and 6th Month	Yes	0/15	(0)
		No	15/15	(100)

VDRL- Venereal Disease Research Laboratory test

LMP- Last day of Monthly Period

E-pill- Emergency contraceptives

PEP- Post Exposure Prophylaxis

STI- Sexually Transmitted Illnesses

Liver Fn- Liver function

After provision of medical care, health providers are supposed to refer patients to other qualified professionals as appropriate to the needs of the survivor. An MSF clinical officer referred the patients to the children's department and police as stated:

"We refer them to the legal department, then we also have children protection... how do they call them?...children department.(Interviewer: Do they provide good service?) The police I think they are well placed because they have a department that deals with this, they have put a female officer to be responsible for follow up of these cases...I can't be sure of the Children's department because most of the times we don't follow up what happens after. At least for the police department we see them her but children department is more of referral."
(MSF clinical officer)

As indicated in the table, only a few patients continued with the PEP. During the in depth interview with one of the counsellors, I sought reasons as to why none of the patients completed the prophylactic drugs dose and the majority did not come for refill of drugs at day 14. She explained:

"We may have a bit of documentation issues on the side of counselling. Its possible that the person came for a retest then it was negative and we told them to go home but its not reflected anywhere on the file. Because the majority of them do come for that final test. So it could be a documentation issue. I actually thought you could tell the other way round. I noticed people disappearing at day 14 because there was a time they couldn't come because they didn't finish their dosage." (MSF counselling psychologist)

Some of the patients could have 'disappeared' due to the fact that they came from far. An example is Edna who came from a place that was 20 minutes' drive away. The hospital could have referred the patients to the nearby health centres to cut transportation costs incurred by the survivors.

3.2 Health facility's capacity to provide post rape care

For a health facility to be able to provide effective health care services, it must have sufficient material resources, human resources and an organized health information system. In Homabay District post rape care services were available 24 hours a day, 7 days a week. Patients seeking post rape care were given priority therefore easy access to the medical officers. Notwithstanding, at certain periods the patient would have to wait for medical officers in case they were conducting ward rounds in the inpatient wards.

3.2.1 Understaffing

As a result of having few health providers, patients received suboptimal care as stated by the government chemist and a laboratory technologist:

“Ideally we should have like 20 minutes for client for that session but the clients are many and we’re few...so the time spent per patient is reduced. So we get rushing through issues that in another setting we could have taken some time depending on nonverbal expression of the client.” (Government Pharmacist)

“If you talk of personnel. If you take like now we are having very few people. Some people are off duty so the personnel are limited. You know those rape cases needs... they might come in and find somebody who has never handled them....” (Government laboratory technologist)

3.2.2 Skills of health care providers

Health care providers felt confident when providing emergency contraceptives, Post exposure prophylaxis (PEP) and adherence counselling. A nurse and a clinician had the following to say about their skills:

“First I can give emergency contraceptive, PEP drugs-ARVs to prevent someone from getting HIV, counselling and how to take the drugs and give STI drugs as a nurse. I am confident because I have had experience for 8 years. Writing statement in police and forensic examination, I am not confident because I have not had training on the same.” (MSF Nurse)

“I can confidently carry out PEP, give emergency contraceptives, a bit of counselling....although am not a counsellor but at least you cannot just leave it like that.” (MSF clinical officer)

Of the 15 health providers interviewed only 3 were mandated to carry out forensic examination. The three felt they could carry out forensic examination confidently and handle the medical legal aspect of the post rape care. The medical officers said:

“Of course HIV counselling. I’ll say counselling and of course the examination part of it. You get confident by seeing many of these cases and dealing with a lot of them, the challenges you encounter and probably in the next case that you get you already know which challenges you’d faced earlier and how to tackle those challenges. So you only get confidence by seeing many of these cases.” (Government medical officer)

“Basically all of them (aspects of post rape care provision). Being a health care provider these are things you go through, you see, it gets easier with time and experience. I have seen 20 cases most who are minors.”
(Government medical officer)

The rest felt that training on the medical legal aspect would be important. They were not confident because they had not training as illustrated:

“Writing statement in police and forensic examination am not confident because I have not had training on the same.” (MSF Nurse)

“I can do counselling, I can also provide STI treatment, PEP, follow up on the vaccinations because am well knowledgeable with that. The taking samples like the High vaginal swab (HVS) maybe samples for DNA I am not experienced. You can only be comfortable if you have been doing it.” (MSF clinical Officer)

However, they lacked confidence in dealing with traumatized patients especially prepubescents:

“...and also to young children. A baby maybe a baby of 4 years, you know counselling is so hard. Maybe you might only talk to the mother but what the baby is going through you might not have a language of counselling a child.” (Government medical officer)

“Sometimes it’s the counselling aspect. Counselling some of those children who are traumatized is not easy and it requires a long time and also being a male when most are victims are female. Few of them are not comfortable.” (MSF clinical Officer)

In addition, health providers experienced difficulty when handling patients who had mental health problems. This is reflected in the following excerpts:

“Another challenge is on the mentally challenged especially when the caretakers are even illiterate its even hard to explain.” (MSF clinical officer)

“Mental health cases-let’s say patients who in addition to being HIV positive or in addition to having been defiled. You’re either an alcoholic, you have a substance issue or you have a kind of psychosis going on or you show depressive features. How to care well for these patients... that needs strengthening. Because the most I can do and if the person is not mentally stable, there isn’t much I can do.... I cannot talk to this person.”

(MSF counselling psychologist)

The lack of confidence was due to the fact that the health providers had not received any form of training on post rape care. Health providers said:

“I have no training.... if there was a kind of program on this, or seminar or a training program to be more precise would make it better (Probe-this meaning?) on these defilement cases.” (Government medical officer)

“I’ll say none(referring to training)Formal training on sexual gender based violence because at times you can be doing things.... but you see only on job training is not enough. The greatest support would be on the trainings.” (MSF clinical officer)

3.2.3 Lack of drugs and medical equipment

In addition to lack of skills, health providers lacked drugs and equipment for use in delivery of post rape care. Through inventory I observed that the facility lacked portable lamps for medical examination and speculums were mostly adult sizes with exception of one for children. Height boards, magnifying lens, tweezers, scissors and combs were lacking. At the time, the outpatient department was out of emergency contraceptives.

Post rape care should be given free of charge in government hospitals as stipulated in the national guidelines on management of sexual violence in Kenya. Despite the regulations, the patients had to take care of some expenses because the health facility did not have some of the drugs and equipment. A government medical officer explained:

“....speculum is not always available. They usually buy the STI drugs that are prescribed and they have to buy gloves when examining. If they have a UTI or STI they cover medication. The thing that is given for free is the PEP, ECs and plus if any stitching is done that is free.” (Government medical officer)

Moreover, the health facility did not have analgesics and the capacity to carry out DNA tests as stated by the government medical officer:

“I’ll say DNA analysis can’t be done. If probably there are vaginal tears and need to be repaired the patient in this facility has to buy the drug i.e. the analgesics, they have to buy sutures to repair vaginal tears.” (Government medical officer)

3.2.4 Lack of stationery

National guidelines on management of sexual violence require that the PRC1 form should be filled in triplicate. The Original form is for the police for custody to be produced in court as evidence, the Duplicate form is for the survivor and the Triplicate form is meant to remain in the hospital. From observation, the PRC1 form was only one copy and the patient had to meet the costs of photocopying the document so as to have a one copy for them police and herself.

Additionally, the guidelines recommend that health facilities offering post rape care should have consents forms, counselling forms, post rape care registers and a gender based violence information package. These documents were lacking from the health facility. All forensic tests and results should be recorded in a laboratory rape register containing information on: name, registration number, date, age, sex, investigations done, results and a place for anyone who takes specimen to sign in order to maintain a chain of custody of evidence. Unavailability of the laboratory rape register compromised the chain of evidence. Lack and insufficiency of forms and registers led to poor compilation of data resulting into poor records.

3.2.5 Poor record keeping

A complete medical record should have consisted of a PRC1 form, P3 form and a medical file. However, with the exception of only one record all the 42 health records were incomplete. Besides that a PRC1 and P3 form should go hand in hand as they are filled by one health provider and are supposed to be produced in courts as evidence in case a survivor decides to seek legal redress. Nonetheless, the PRC1 forms were missing P3 forms and vice versa. Only 7 out of 42 records had both a PRC1 and P3 form. The table below gives picture of the disarray in record keeping at Homabay District hospital.

Table 3: Health records of defiled minors at Homabay District Hospital

Variable		Proportion	Total (%)
Age	4-7	9/42	(21.4)
	8-11	10/42	(23.8)
	12-15	20/42	(47.6)
	16-19	3/42	(7.1)
PRC1	Yes	26/42	(61.9)
	No	16/42	(38.10)
Medical examination form /P3	Yes	16/42	(38.10)
	No	26/42	(61.9)
Both P3 & PRC1	Yes	7/42	(16.7)
	No	35/42	(83.3)
Medical files	Yes	14/42	(33.3)
	No	28/42	(66.7)
PEP register	Yes	14/42	(33.3)
	No	28/42	(66.7)
Complete	Yes	1/42	(2.4)
	No	41/42	(97.6)

3.3 Health providers' knowledge on sexual violence and post rape care

Health providers need to have knowledge of relevant terms, existing guidelines, on causes of illnesses, predisposing factors, care provision and be aware of patients' rights.

3.3.1 Understanding of relevant terms

The study sought to find out the understanding of terms as used in the National guidelines on management of sexual violence in Kenya and the Kenya Sexual Offences Act 2006. As per the Sexual offences Act, a child is any person below the age of 18. 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 or social taboos of society. Defilement as per the national guidelines is an act which causes penetration of a child's genital organs. As per the guidelines emergency contraceptives can be given up to 120 hours after defilement. Health providers gave different definitions when asked on their understanding of a child, child sexual abuse, child

defilement and emergency contraceptives. When it came to the definition of a child there were different opinions as indicated below:

“A child is any person who is less than 18 years is treated as a child. But then when we narrow it down there is the minor and a child who occasionally can do things on their own. Is called a minor or a minor adult or a minor something is the second name that am missing but anyone above around 15 years can be treated as an adult and also a child who has conceived definitely that is a minor adult.” (Government clinical officer)

“A child is anyone between ages of 2-12yrs.” (Government medical officer)

“A child is somebody who is less than 15 years as per WHO.” (MSF clinical officer)

Furthermore, most health providers could not differentiate between child sexual abuse and child defilement. They thought that the terms were synonymous as illustrated:

“Child sexual abuse is a child who has been maybe molested or touched, you know not necessarily the intercourse might not have taken place but molested in any way sexually. Yeah or even raped. Child defilement is like more the same, like sexual abuse. A child who has been molested sexually.” (MSF pharmaceutical technologist)

“Child sexual abuse is engaging in sexual intercourse with a minor less than 15years. Defilement is the same definition as child sexual abuse. Its engaging in sexual intercourse with a minor less than 15 years.” (MSF clinical officer)

Only a handful could differentiate the two terms. A government medical officer explained the difference between child sexual abuse and defilement as:

“Child sexual abuse is any sexual intention to a child whether is by touching, fondling, sex. Defilement is when the child has been abused sexually basically there’s penetration in whichever form, oral, anal or vaginal.” (Government medical officer)

3.3.2 Existing guidelines on post rape care

The unfamiliarity of health providers with the national guidelines on management of sexual violence in Kenya was a hindrance to their utilization in administration of post rape. Most of them used the post exposure prophylaxis (PEP) guidelines as indicated in the excerpts below:

“We use the government guidelines, its actually in the ARVs guidelines. The PEP guideline also talks about post rape care.” (MSF clinical Officer)

“We use government guidelines on PEP where we use combivir and Kaletra. Those are the latest guidelines we use. This changes from facility to facility. But the guidelines we’re using are the WHO which have been adopted by the Government of Kenya (GOK).” (Government medical officer)

Others were not conversant with of any guidelines and only alluded to their on job training:

“That is just how I have been taught, I don’t know about the guidelines or algorithms. But it’s a logical approach because algorithms are rigid and you can’t (pause) its a logical approach that’s what I can say.” (Government pharmacist)

As a consequence of lack of knowledge on the guidelines, most of the health providers believed that emergency contraceptives were to be given within 72 hours of occurrence of sexual assault instead of 120 hours:

“Emergency pill is administered within 72 hours after coitus to prevent unwanted pregnancy.” (Government nurse)

“These are contraceptives given to avoid unwanted pregnancies usually given within 72 hours after someone has had intercourse.” (MSF clinical officer)

“...we give emergency pills to people who have had sex in the last 72 hours, the period has to be 72hours.” (Government medical officer)

Moreover, health providers were unaware the guidelines stated that if a survivor presents with a pregnancy, which they feel is as a consequence of the rape, they should be informed that in Kenya, termination of pregnancy may be allowed after rape (Sexual Offences Act, 2006). If they opt for termination, she should be treated with compassion, and referred appropriately. The views below reflect their lack of knowledge:

“We have some kind of Ministry of health (MOH) guidelines, guidelines on how to examine them, what tests to do, what drugs to start and where to refer to other specialists. (Interviewer: guideline on abortion?) I am not sure but I think what they say is abortion is only legal if there are medical indications for that. That’s what I remember I think in 2010.” (MSF clinical Officer)

“Abortion is a crime in the nation. You might not advise them even to try because first of all is not allowed. But it also you know that child there’s that torture. But its just...you counsel them, you feel for them, you be in their shoes, empathetic anyway.” (MSF nurse)

“Personally I don’t like the idea of abortion. I’ll just leave it at that. Personally no I won’t do it. But if they want the services I’ll refer. Not doing it doesn’t mean I won’t not refer to someone who is comfortable. I am not sure what guidelines say. I only know in medical emergencies where mother’s life at risk. I wouldn’t know about defiled children.” (MSF clinical officer)

3.3.3 Causes of defilement

Moral decadence, curiosity among men and rape myths in the community were considered as the probable causes of defilement among minors. Health providers said:

“There are some people who believe if they have sex with a young baby or child who has never had sex before they will be healed. They know they’re HIV positive so they feel that if they go and have sex with a small child that they’ll be healed and that’s why you get the attack on small child is very frequent.” (Government medical officer)

“.....the aspect of inquisitiveness, people tend to be inquisitive to know what does this bottle carry and the other, these could be the driving force but will not say they predisposing but may be the driving force behind that now. One thing that could make them vulnerable (pause) the attire that some wear. They put on a lot provocative clothes that anyone in the conscious mind may feel provoked.” (Male Government clinical officer)

From the informal conversations, I gathered that men were considered to be a curious lot in terms of their sexuality. They would have sexual intercourse with several women of different ages for experimental purposes. If a woman dressed in a sexy manner then a man who is not able to control himself will be provoked and defile a girl for his gratification. Additionally, the majority of the community was Christian and therefore modesty was considered to be a very important concept as illustrated in the excerpt below:

“I don’t blame a child for that sexual abuse because they are simply people who need instructions from parents. If a parent doesn’t put this child into a Christian way of life, you know, not just calling yourself a Christian. You know people even go to church naked.....that church is not displaying Christian values. It should be a church that understands the values of... the values that can remove people or girls from immorality.....but when somebody goes to church wearing a mini skirt...now that one is.....immorality?” (Government laboratory technologist)

The participant used the term naked to describe indecent dressing. Indecent dressing according to him was the same as immorality.

3.3.4 Predisposing factors

Factors that made children susceptible to sexual abuse were poverty which made enticement of children with sweets or sometimes a meal easy. Mentally retarded and orphaned children were also viewed as vulnerable groups. Negligence of children by parents was also seen as a factor contributing to vulnerability as reflected by the comments below:

“Most of them stay away from parents. Most mothers are business women, they are away from their children. And then orphans sleeping in their grandmother’s kitchen.” (Government nurse)

“...the other vulnerability that we’ve seen are mentally retarded children...because they are vulnerable because they are mentally retarded they are just home on their own so strangers and other people and even relatives take advantage of this children.” (Government medical officer)

3.3.5 Post rape care

Health providers were knowledgeable on what post rape care entailed in post rape care as stated in the following examples:

“Care that is given to a victim of rape. Its comprehensive, physical examination of the victim, observation of the patient, the inner wear is torn or not. Taking samples, high vaginal swab looking for semen and bleeding. Then there’s also therapy pharmaceutical in nature. Therapy in terms of counselling then the documented evidence is taken to the police for them to take action. Pharmacotherapy maybe if she’s pregnant or but that’s case by case issue. Pharmacy aspect if the culprit is not on hand you may want to start on PEP for HIV, you may want to do pregnancy test to prevent the pregnancy, you may also want to target other STIs, hepatitis, syphilis, and chlamydia is case by case. Emergency pills because you had penetrative sex and there’s a high potential for fertilization so you want to prevent that from happening so you use a high dose of oral contraceptives.” (Government pharmacist)

“It includes the care given to patients or victims who have been raped and it entails counselling. It entails testing patients and starting on PEP, if ladies or girls we normally give emergency contraceptives. If there are any vaginal tears, these children are normally. We normally repair the vaginal tears. In terms of post rape care there’s counselling, surgical care and medications. The counselling that we give first is counselling on HIV. We tell them if you get HIV is not the end of the world, if they don’t have its good, we tell them to protect themselves if they’re going to have any sexual encounter. We counsel them to be free to be open to share with us, the experience they went through, we need to know whether they are traumatized or not, they are counselled and also followed up on the same.” (Government medical officer)

However when asked if there was difference in care for minors and adults, most health providers thought there was only a slight difference as stated below:

“Difference (pause) collection of sample, in this scenario the main sample is the same, same site that we go for in a child and adult not unless there is a complication where one is incapacitated. Site for collection is the same, the equipment of collection- its only the size that differs. There are smaller ones available ranging from metallic to plastic ones. In children below 12yrs, we don’t give ECs (Emergency contraceptives).” (Government clinical officer)

“They get the same treatment, same medication just the dosage is what will be different. (Pause) No ECs for prepubertals. Same care all of them apart from dosage, there’s nothing much.” (Government medical officer)

3.3.6 Rights of patients

As pertaining to the rights of defiled patients, health providers mainly stated that the patients had a right to treatment, medical legal services and psycho social support which they felt they did provide. The following examples highlight the rights of patients as:

“....entitled to the right for medical care and probably. Not sure but they are also supposed to go to court and be heard but in this facility I’ll just say medical care in all its forms in terms of physical, medical care and emotionally they need counselling.” (Government medical officer)

“They have a right to access PEP drugs to curb transmission of HIV Virus. The second right is that they have to be given medications that prevent acquisition of STIs. The third right is that the culprit, the one who commits the offence should be brought to book etc.” (Government clinical officer)

“Their rights is to know there HIV status, after that their right is to know if they’re pregnant to know what would be the outcome, and right for medications if to be put any and right to sue the person.”
(Government medical officer)

Only a few mentioned that the patients had a right to protection, privacy, confidentiality and respect. A government nurse said:

“They have a right to privacy, right to get their treatment, right to know what you’re doing to them, right to be respected as individuals and they have a right to get that medical care.” (Government nurse)

There was a lot of stigma in regard to sexual assault because the community valued chastity, a value supported by the culture and religion. Hence survivors of sexual assault would be keen on privacy and confidentiality. In addition, sexual assault causes survivors to feel powerless and therefore health providers need to make them feel like they are in control. Therefore, health providers should respect the patient by asking her for permission before undertaking any procedure and involve her in decision making for treatment.

3.4 Attitudes of health providers towards components of post rape care and survivors

3.4.1 Attitudes towards emergency contraceptives

Health providers believed that emergency contraceptives were very important as they prevented unwanted pregnancies. Their positive attitude towards emergency contraceptives is illustrated in the excerpts below:

“My opinion is that they need it especially if they are of reproductive age. They need it because number one they didn’t expect to be pregnant, most of the time these children who are in school, if they’re to get pregnant pregnancy itself will disrupt their education so in my opinion they need the contraceptives.” (Government medical Officer)

“Am for it, I support it to prevent unwanted pregnancies, it’s a child you don’t want to give a child another child to take care of, and probably they come from abject poverty so you’re adding on to the burden.”
(Government medical officer)

3.4.2 Abortion services

In contrast, abortion services for sexually abused minors proved to be a contentious issue. Most of the health providers were not comfortable with offering abortion services to

minors who might get pregnant as a result of defilement. Their discomfort was expressed in the following views:

“For me procuring an abortion is a no that is like killing, taking a way a life that is an innocent life. I would rather prepare the mother, take her through some psychological counselling but not procure an abortion. I think the guidelines does agree to that (pause) the guideline has a provision for that but for me am not for it. What would you do if you were me? What will you do? Procure an abortion for purposes of following the guidelines. Would you? Really? (I was shrugging my shoulders as if in agreement) because the guidelines say. I would not do it, it is not seconded by religion. I believe if the same were done to me, I would not have existed.”
(Government clinical officer)

“(sighs) Abortion no. Because of religion. I am catholic. In Kenya abortion is a crime. Abortion is done if there is any risk to the mother like if a patient has preeclampsia or eclampsia this pregnancy is causing a problem that is killing the mother. Abortion due to rape is a crime.” (Government medical officer)

“Abortion is risky. Abortion might lead to infertility, abortion might lead to infection. Abortion is not allowed. Ethics does not allow it.” (Government nurse)

Only 2 out of the 15 health providers interviewed felt that abortion services should be given to sexually abused minors. A government medical officer who considered himself pro-abortion said:

“Well I am pro-abortion myself, any woman in my own opinion, any woman who feels that that they don’t need that baby that child they didn’t plan for she needs an abortion. They should be given, it is better we give abortion services in the health care facility rather than procure in unsafe environments. Most of the time these patients who require abortions they have already made up their minds that they want an abortion whether you provide or not (what do guidelines say) there are no guidelines on abortion.” (Government medical officer)

3.4.3 Blaming of survivors

Different responses were given by health providers when asked if they thought that at times defiled children were to blame for being sexually abused. Some of the health providers felt that sexually abused minors were not to blame for sexual abuse. A government medical officer explained:

“No, they are children, they basically don’t know what they are doing, they are gullible and they are easy to convince.” (Government medical officer)

On the other hand, others especially male respondents felt that sexually abused minors at times bore the blame. Their opinions were as follows:

“Yeab..yeab (agreeing that sometimes minors are to blame for sexual abuse)...I would say that because there are some cases is a defilement case because the child is under 18 but she is the one that was done with the consent so I would say in some cases you can blame them.” (Government medical officer)

“Yes, the kind of clothes that they put on. They put on provocative ...clothes that expose a big chunk of their body and may be the person interacting with her to some extent may start developing feelings that may lead to the act.” (MSF clinical officer)

Although the laws stipulated that a child was anyone below 18 years of age, many community members health providers included viewed adolescent girls as mature. Hence to them if an adolescent girl consented to sex then it was not a crime. Modesty was considered a virtue as the community was religious and the girls were obligated to comply in order not to provoke the men.

3.4.4 Lack of empathy

The discourses used in interviews by the health providers reflected lack of awareness on the sensitive nature of sexual abuse. Some of the health providers referred to survivors of sexual abuse as culprits during the interviews as expressed in the following excerpts:

“O.k... when the act happens.... then a child happens to be a culprit...now to prevent the culprit from continuous suffering, then there are things we can curb things like HIV transmission to one who was innocent, if there is a way on how it is prevented then we do that, prevent unintended pregnancy.” (Government clinical officer)

When asked if all children who have experienced sexual abuse deserve to be given post rape care a government clinician answered:

“Yes, for good health. Post rape care doesn't really entail medicines...each and every culprit deserves.” (Government clinical officer)

CHAPTER FOUR

4.0 Discussion

This study to the best of my knowledge is the first study to be conducted in Kenya. The findings indicate that the incidences of sexual abuse among minors were attributed to vulnerabilities created by poverty, mental health problems, loss of parents and negligence by the caregivers in the community. Similar findings have been documented elsewhere (Berliner & Conte, 1995; Burgess & Holmstrom, 1975; Finkelhor & Barondo, 1986). These vulnerabilities made minors an easy target for perpetrators of sexual violence. Sexual offenders usually select their victim (s) based on their vulnerability and accessibility (Mason & Lodrick, 2013). The study found that one of the causes of sexual abuse was social fictions which had permeated the community. There was a belief in the community that if one was HIV positive, they could be cured by having sexual intercourse with a virgin. Lalor (2004) discusses child sexual abuse as a HIV/ STI avoidance strategy in reference to a study conducted by Meursing, et al. (1995) in Zimbabwe whereby two cases were reported of young girls who became infected with HIV and STD as a result of 'cleansing' practices. Homa Bay County has the highest prevalence of HIV (27.1%) in Kenya (UNAIDS & NACC, 2014) and therefore believes that sexual intercourse with a virgin cured HIV placed adolescent girls at risk for sexual abuse as well contraction of HIV virus. Curiosity in men was also considered a cause of defilement in the community as they were viewed to be experimental in nature with regard to their sexuality. Findings supporting this phenomenon have not been discussed elsewhere to the best of my knowledge. The finding could be specific to Homa Bay but relevance lies in demonstration of how societies excuse and tolerate sexual violence. In an incident that occurred in 1991 in Kenya, 19 secondary schoolgirls were killed and 71 others were raped by male students in their dormitory at St. Kizito in Meru (Perlez, 1991). The deputy principal at the school was reported to have said that the boys had never meant any harm against the girls instead they just wanted to rape (Perlez, 1991). This may have been an isolated incident but it speaks volumes in terms of condoning aggression against minors and women. In addition, 'indecent' in women was considered a cause because it 'provoked' men. This finding is similar to a 2010 survey of UK residents where 56% of the respondents thought that there were some circumstances where a person should accept responsibility for being raped (Opinion Matters, 2010). One of the circumstances was provocative dressing supported by 28% of the population. In our study setting, the community was male dominated with men seen as people who could not control their sexual urges and therefore women had the

responsibility of not provoking the men (Opinion Matters, 2010). Social attitudes toward sexual abuse and women are an obstacle to containing the alarming level of sexual abuse in Homa Bay. There is need for sensitization of the community on sexual and gender based violence in order to dispel fictions promoting sexual violence against minors and highlight the gravity of sexual abuse.

While survivors of sexual abuse need to be provided care that is of high quality, the study shows that the health facility management did not provide protocols/ algorithms to guide the provision of post rape care. Thus health providers had no systemized way of delivering post rape care. Similar findings were found in a study conducted in Northern Uganda whereby among the eight health facilities that had been visited, only one used a protocol for treating survivors of sexual violence (Henttonen, Watts, Roberts, Kaducu, & Borcherte, 2008). Lack of algorithms in health facilities promotes poor delivery of post rape care services. Survivors may miss out on some aspects of post rape care due to failure by health providers to remember some treatment procedures e.g. forgetting to test survivors for STIs or pregnancy, collecting only a few samples for forensic examination etc. Algorithms are useful instructions especially for inexperienced health providers or those unfamiliar with the procedures entailed in post rape care delivery. Even for experienced health providers, they act as reminders for complex procedures facilitating better care and thus favourable health outcomes for survivors of sexual abuse.

The study found that the health facility lacked medical supplies and drugs essential for delivery of post rape care. As a result, there was poor collection and analysis of specimens for juridical purposes. Furthermore, lack of medical supplies and drugs implied that the survivors had to incur extra costs in order to get treatment which is supposed to be free of charge according to the National guidelines on Management of Sexual violence. In the event that the survivors could not have afforded the extra costs, they would be left with unmet needs. A study conducted in Kenya showed specimen collection of sufficient standard for juridical purposes was hampered by the lack of the required equipment (Ajema, Mukoma, Kilonzo, Bwire, & Otvombe, 2011). Costly healthcare could be a deterrent to health seeking behaviour in survivors of sexual abuse as well as patients in general. Hence facilities offering post rape care should be well equipped and stocked with enough drugs in order to meet the needs of sexually abused survivors.

Study findings also indicated a dearth of stationery in the health facility. Consent forms, counselling forms, laboratory and exhibit registers, triplicate legal forms and information

packages on gender based sexual violence were lacking in the health facility. Consent forms are vital in ensuring that health providers obtain informed consent before giving care and it goes hand in hand with preparation of the survivor for examination and treatment. Jina, et al. (2010) argue that survivors of sexual abuse experience a profound sense of powerlessness during the rape thus it's important that every aspect of post rape care is provided in a manner that enables survivors to feel empowered. Therefore the health provider has a duty to give thorough explanations about health care, tests, and treatment options including adverse effects (Jina, et al., 2010). In Kenya, written informed consent is recommended because it protects the health providers against legal suits as survivors are allowed to sue health professionals for examining them without consent (MOMS & MOPHS, 2009). Absence of counselling forms hindered note taking during the counselling sessions. Resultantly, counsellors did not have notes for reference in subsequent sessions. Lack of reference notes for counsellors could have resorted to survivors being asked the same questions therefore a possible indication that their situation is trivialized. Laboratory and exhibit registers are important in maintaining chain of evidence as they provide details of the transfer of specimens between individuals (MOMS & MOPHS, 2009). Scarcity of triplicate PRC1 forms meant survivors had the responsibility of making copies of the forms. As a result, some of the forms were missing because patients failed to bring them back and others were misplaced. Lack of PRC1 forms for already examined survivors could have severe implications for court cases as the health providers would not have reference material for their testimony. Health providers in Homabay District Hospital were few and therefore may not be able to give survivors all the information needed to address their concerns. Hence, there was need for gender based violence information packages that contained detailed information in terms of where to seek services that may not be available in the health facility and issues regarding legal proceedings. Forms and registers are important in post rape care as they ensure documentation of clinical, medico-legal and psycho social support procedures. Documentation allows for assessment and evaluation of post rape care services for better health outcomes. Hence there is need for development and maintenance of a health information system that enables the health providers to record and retrieve patient information easily.

As per the findings of this study, the health facility was understaffed. Consequently, survivors of sexual assault experienced delays as in obtaining post rape care in the health facility. Furthermore, some patients had to revisit the facility multiple times for care that could have been offered in a day. Delays at the health facility could discourage survivors in seeking post rape care or not adhere to treatment in the case of follow ups. Ajema, et al. (2011) discuss shortage of

medical doctors required to examine survivors of sexual violence reporting to public health facilities in Kenya. The study elaborates further that only medical doctors could act as “Expert witnesses” in cases of sexual violence. However, the current guidelines have a provision that allows nurses and clinical officers to conduct the forensic examination (MOMS & MOPHS, 2009). Despite the provision and shortage of medical officers in Homa Bay District Hospital, only medical officers were mandated to conduct the forensic examination as per the study findings. Over reliance on limited number of doctors and medical officers in health facilities to conduct the forensic examination continues to cause delays in provision of post rape care. There is need for nurses to be trained so as to reduce the delays. In training of the nurses, Homa Bay District hospital may want to borrow some concepts from the sexual assault nurse examiner (SANE) programs in the United States of America whereby specially trained forensic nurses provide 24-hour-a-day, first-response medical care and crisis intervention to rape survivors in health facilities (Aiken & Speck, 1995). From the literature review of the SANE programs, it is reported that they promote the psychological recovery of rape survivors, provide comprehensive medical care, obtain forensic evidence correctly and accurately, and facilitate the prosecution of rape cases (Campbell, Patterson, & Lichty, 2005).

The study found that health providers were not conversant with the existing national guidelines on management of sexual violence despite their existence since 2009. The lack of knowledge could be attributed to the fact that health providers had not been trained on post rape care. As a result, forensic examinations were conducted poorly characterized by poor specimen collection. An evaluation of quality of care for rape survivors in South Africa showed that health providers had problems in collecting forensic evidence due to introduction of new kits as they had not been trained on their use (Christofides, et al., 2005). Forensic evidence collected from survivors of sexual abuse is vital as it assists law enforcement with the investigation of the abuse (Ferguson, 2006). Additionally, forensic evidence corroborates the testimony of the survivor and that being the case; its absence might challenge prosecution of offenders. Furthermore, trauma counselling was not offered to survivors of sexual abuse as indicate in the findings. A lot of survivors of sexual violence maybe traumatized during rape and suffer from post-traumatic stress disorder hence the importance of trauma counselling. A literature review on sexual and gender based violence in Africa revealed that counselling services for survivors of sexual violence are not well established (Population Council, 2008). Trauma counselling assists in prevention of long-term psychological sequelae that result from sexual assault and generates cycles of violence (The Lancet, 2009). Moreover, it can also prevent

maladaptive behaviour patterns such as risky sexual behaviour and help the survivors prevent revictimization (Donenberg & Pao, 2004; Donenberg & Pao, 2003). Lack of knowledge on existing guidelines was a major contribution to poor delivery of post rape care services. The needs of the survivors were unmet with possibilities of engagement in activities that could deteriorate their health. In order for survivors to attain better health outcomes, there is need for sensitization of health providers on existing guidelines and intensive training for effective service delivery.

Findings demonstrate that most health providers felt confident in their ability to provide emergency contraceptives, non-occupational HIV PEP and adherence counselling despite their inadequacies. For instance, the nurses and clinicians had confidence in their ability to provide emergency contraceptives, non-occupational HIV PEP and adherence counselling. However going through medical records, the emergency contraceptives were given without performing the pregnancy tests and only patients who came within 72 hours of the sexual assault were given the emergency contraceptives. This practice could result into missed opportunities for survivors who come after the 72 hours but within 120 hours of the sexual assault as they would not be given emergency contraceptives placing them at risk for unwanted pregnancies. Non-occupational HIV PEP was administered without the baseline haemoglobin tests putting anaemic patients at risk. Moreover, nurses and clinicians admitted to lack of confidence in performing forensic examination due to absence of training programs. Findings from a cross sectional study conducted in South Africa on knowledge and confidence of South African health care providers regarding post rape care showed that the knowledge of providers working in post rape care was low and recommended training to be improved (Jina & Thomas, 2013). The same study also indicated that many of the health providers were not completely confident in delivering every aspect of post rape care (Jina & Thomas, 2013). Lack of training for health providers on post rape care and sexual gender based violence results into missed opportunities and unmet needs for survivors of sexual assault. Health providers should be trained on post rape care and sexual gender based violence in order to prevent dissemination of bad practice through on job experience.

Training should also ensure that health providers are familiar with terminologies used in defining sexual violence. Documentation of child sexual abuse requires clear definitions and an understanding that it is a problem (Lachman, 2004). Therefore, the need to develop a good understanding of how the public, policy makers, and professionals define child sexual abuse (Pierce & Bozalek, 2004; Lalor, 2004). The findings of this study show that most of the health

providers could not differentiate defilement and child sexual abuse. Furthermore, health providers had different definitions of a child. When health providers equate defilement to sexual abuse, then children who might have experienced other forms of sexual abuse e .g. oral sex, fondling, exposure to pornography etc. are not likely to be perceived as deserving care. The use of wrong terminologies in a court of law could damage the integrity of the evidence as well the witness' (health provider) credibility.

Findings from this study show that health providers had different attitudes to sexually abused minors and various aspects of post rape care. The study found that some of the health providers blamed girls who had been defiled for the sexual abuse. In the Homa Bay community, failure of conformity to the decency rules was considered immorality possibly justifying sexual abuse against women. Other studies suggest that men who hold sexist attitudes portray women as either “good girls” or “bad girls” and therefore, non-conformity to the cultural stereotypes of a “good girl” may lead to one being blamed for leading their partners on and regarded as deserving to be raped (Burt, 1980; Forbes & Adam-Curtis, 2001). Health providers who think patients are at fault may not always provide the best care and might end up punishing the patients by denying them some services in order to teach them a lesson. Moreover, some of the health providers lacked sensitivity and empathy for survivors of sexual assault. Survivors' health outcomes are poorer if they are received unsympathetically, blamed for the sexual abuse, ignored or discouraged from expressing their feelings (Campbell, Collumbien, & Southwick, 1999).

The findings showed that emergency contraceptives were issued without reservations from the health providers perhaps because of the emphasis that they were not a form of abortion. A study conducted in Lagos revealed that health providers had a high degree of awareness of and a largely favourable disposition toward emergency contraceptives (Olufunke , Osaretin , & Inem , 2006). Nonetheless, as shown from the review of medical files, emergency contraceptives were not offered consistently. These findings are similar with reports from other sub Saharan studies which had reported that emergency contraception to prevent pregnancy resulting from rape was not consistently offered to survivors (Martin, Young, Billings, & Bross, 2007). Findings also showed that some of the health providers had a negative attitude towards offering abortion services for minors who became pregnant as a result of the sexual abuse. This could have been due to the criminalization of abortion by the government (except for when the mother's life was at risk) as well as lack of knowledge on existing guidelines regarding abortion services to pregnant sexually abused minors. Religion also played a key role in the negative attitude as most of the health providers equated abortion to killing which was sinful in the

Christian faith. A study by Aboagye, et al. (2007) in Ghana, found that provider hesitance in providing abortions was because of perceived religious conflicts as well as uncertainty of the legality of abortion, doubts about the standards and protocols for abortion care, and perceived lack of administrative support. Perceived lack of administrative support was not part of my study findings as I didn't look at that aspect in my interviews. Similar findings have been documented elsewhere (Mokgethi, Ehlers, & Van der Merwe, 2006; Harries, Stinson, & Orner, 2009; Aniteye & Mayhew, 2013). Negative attitudes of health providers towards certain aspects of post rape care may deny survivors of sexual abuse their right to reproductive health and may also encourage unsafe abortions among minors who have experienced sexual abuse. Thus, there is need for sensitization of health providers on how their attitude affects health outcomes of survivors.

Low adherence to PEP medication by the patients was observed from the findings. Findings from other studies on HIV post exposure prophylaxis for sexually abused children conducted in Malawi, Kenya, and Uganda show a mean adherence rate of 55% (Ellis, Ahmad, & Molyneux, 2005; Speight, et al., 2006; Haworth, 2006). A study conducted by Collings, Bugwandeen, & Wiles (2008) in South Africa indicated that adherence rates to PEP were low and the low adherence rates were associated with a theoretical risk of both reduced efficacy and drug resistance. In addition, Ellis, Ahmad, & Molyneux (2005) states that reasons for non-adherence are likely to be "multiple and complex," and may include adverse drug reactions, care-taker issues and/or societal issues. In the follow up of my cases adverse drug reactions or care-taker issues were not cited as a problem to non-adherence. Societal issues played a bigger role and may have trivialized side effects and care taker issues. Findings from this study revealed that the community treated child sexual abuse as a private matter and resorted to the traditional justice system. The community justice system demand payment of fines (mainly in form of cash or animals) by the perpetrator to the guardians of the abused minor. However, the legal system identifies child sexual abuse as a crime against the state and therefore demands harsh punishment of perpetrators. Therefore guardians end up hiding their children from law enforcement by claiming that they are lost or have visited distant relatives and the minors end up not adhering to the treatment plan. This phenomenon has not been discussed elsewhere as a probable cause for non-adherence. Nonetheless, literature indicates that common traditional punishments, such as payoffs to the survivor's family or marriage between the survivor and perpetrator, often undermine legislative enactments and criminal sanctions (Kilonzo, et al., 2009). This study also identifies delays at the point of service delivery as possible factors for low

adherence rates. Delays in provision of post rape care at the health facility could have been a deterrent to continuation of treatment by patients. Survivors also experienced delays at the police station when they sought legal redress as indicated by the findings. They were required to give statements on numerous occasions. Moreover, health providers also claimed that there were allegations of corruption at police centres where police demanded bribes in order to arrest the perpetrators. The health facility worked in collaboration with the police in addressing medico legal needs of the patients. As a result, the frustrations faced at the police station could have led to distrust of the police as well as health facility and patients could consequently withdraw from the treatment process. Findings show that some of the minors came from distant places and were no able to meet transportation costs for follow up. Logistical barriers have been cited by Kim, Martin, & Denny (2003) as hindrances to PEP adherence. The study found that the health providers contributed to the non-adherence by not referring the patients to nearby health centres for continuation of PEP in order to improve adherence. Speight et al. (2006) suggests that the use of community based or health centre follow up can improve the quality of data on adherence as well as providing potential support opportunity for rape survivors. Societal issues, logistical barriers and delays both at the police station and the health facility were obstacles to adherence. Therefore there's need for collaboration between the community, the health facility and the police administration to work round the obstacles in order to promote adherence due to the high risk of HIV sero conversion.

4.1 Strengths and weaknesses of the study

The study used a triangulation of methods which yielded rich in depth data as well as enabling the researcher to verify the information provided hence validity of the study. Moreover, the study was conducted by the researcher who collected the data, performed the analysis, presented and discussed the findings hence a better understanding of meanings and their interpretation. During the analysis process, the researcher engaged her colleagues and supervisors in coming up with codes and themes in order to decrease bias. In addition, the researcher came from the same country as research participants and spoke their language making communication easy as she understood the local nuances. The researcher was considered a member of the community as she originated from a neighbouring community which was regarded as “Shemeji” translating to in-law because of a lot of intermarriages between the two communities. Therefore, participants were more than willing to divulge information regarding child sexual abuse. The researcher's age, enabled her to relate well with the adolescents who opened up by sharing their ordeals despite the sensitivity of the issue.

The research design does not allow for generalization of the study findings. However, the settings have been described and methodology detailed in order to allow for transferability. In the research protocol, the plan was to explore the perceptions of sexually abused children and the care givers on post rape care. Interview of care givers was not possible as most of the defiled minors came to the health facility accompanied by their siblings who were also minors. The medical files lacked contacts which could have been useful in tracking caregivers retrospectively. Furthermore, health providers went on a national wide three week strike. As a result, no interviews were conducted during that period. The researcher had also planned to carry out a comparative study of health facilities providing post rape care. However, ethics approval and research permits were given after a waiting period of 2 months which delayed commencement of the study. Thus, the researcher decided to focus on two objectives and assessed quality of care based on structure, processes and outcome of one health facility.

4.2 Conclusions and recommendations

This is the first qualitative study conducted in Kenya assessing quality of post rape care provision to sexually abused minors in a rural hospital and contributes new knowledge on how the services are being delivered. Findings from the study showed that Homa Bay district hospital was receiving an alarming rate of minors who had been sexually abused. Existing social attitudes toward sexual abuse and women were an obstacle to containing the rising incidences of sexual abuse among minors. The study found that the health facility lacked algorithms, medical supplies, drugs and stationery which were essential for post rape care delivery. Furthermore, health providers had not been trained on post rape care delivery and sexual gender based violence. As a result, services provided to survivors of sexual abuse were poor and inadequate. The study also found out that the health providers had negative attitudes towards survivors of sexual abuse and abortion care. In addition, adherence to HIV PEP medication was hampered by societal issues, logistical barriers and delays both at the police station and the health facility.

With regard to the aforementioned limitations, there's need for Homa Bay District Hospital and health facilities with similar settings to make drastic changes in the health system in order to meet the needs of minors who have experienced sexual abuse. The key recommendations are as follows:

1. Development of algorithms which are in line with current knowledge to guide provision of post rape care to sexually abused minors.

2. Equipping Homa Bay District hospital with medical supplies, drugs and stationery for better delivery of post rape care.
3. Focussed training of the health providers on post rape care, sexual and gender based violence. The nurses should be trained in forensic examination so as to prevent delays whereby survivors have to wait for medical officers.
4. Attitude change programs for the community on sexual and gender based violence in order to dispel myths on rape and improve social attitudes towards girls and women.
5. Establishment of collaboration units between the different stakeholders involved in offering care and support for sexually abused minors e.g. the police administration, children's department, local administration etc. Collaboration will ensure that survivors of sexual abuse access services that cannot be provided by the health facility.

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APPENDICES

Appendix 1: Thematic interview guide for health providers (nurses, medical officers & clinical officers)

Personal background information

Profession:

Health facility:

Education/ Qualification:

Understanding of terms used in the Kenya sexual Offences ACT and Kenya national guidelines on Management of Child Sexual Abuse

What's your definition of a child?

How do you define child sexual abuse?

How do you define child defilement?

What's your definition of post rape care?

What's your definition of emergency contraception?

Perceptions on causes and consequences of child sexual abuse

What's your role as a clinician/ nurse/doctor in the provision of post rape care?

How would you rate the occurrence of child defilement cases in the community?

Who would you say are the main perpetrators of sexual abuse in this community?

In your opinion what makes children in this community vulnerable to sexual abuse?

Do you think some sexually abused children are to blame for being sexually abused? Why?

Training

What trainings have you undergone to capacity build you on delivery of post rape care to children?

Post rape care services administration

Why should post rape care be given to defiled children?

Can you mention some rights that the defiled patients are entitled to in this facility?

How do you ensure that the patient these rights are observed?

What is entailed in the post rape care?

What protocols do you follow when administering post rape care?

What is entailed in forensic examination of children?

Probe- samples

What's the purpose of forensic examination?

What aspects of forensic examination cannot be conducted at this clinic?

What's your role in the legal process?

What's chain of evidence?

How do you maintain chain of evidence?

Do you think all defiled children deserve to be given post rape care?

What are your opinions on the emergency contraception being given to defiled children?

What are your opinions on provision of abortion services to sexually abused adolescents who get pregnant as a result of the abuse?

How do you categorize survivors of sexual abuse?

In what ways does post rape care given to adults differ from that given to children?

What is the purpose of tanner staging?

Skills

What aspects of post rape care delivery do you think you can carry out confidently?

What aspects of post rape care do you feel you cannot carry out confidently?

Probe- what makes you not confident?

Which kind of help /education would make you better/ confident?

Referral services

Are there any other institutions/ clinics that you refer the sexually abused children to?

Do you think these institutions/clinics are well placed to offer the services they specialize in?

What challenges do you experience when administering the post rape care?

Please describe your worst experience in your work related to delivery of post rape care to children.

Institutional support to avoid burnout among employees

What support has the institution given you to enable you deliver post rape care to children?

What more support do you think the institution should provide to enable you work better?

Appendix 2: Thematic interview guide for health providers (pharmacists)

Personal background information

Profession:

Health facility:

Education/ Qualification:

Understanding of terms used in the Kenya sexual Offences ACT and Kenya national guidelines on Management of Child Sexual Abuse

What's your definition of a child?

How do you define child sexual abuse?

How do you define child defilement?

What's your definition of post rape care?

What's your definition of emergency contraception?

Pharmaceutical management

What role do you play in delivery of post rape care for defiled children?

What drugs do you dispense to defiled minors? How do you determine the dosages for different ages?

Probe- Which drugs for what purpose?

-What dosing intervals?

How do you follow up on issues of side effects?

How do you follow up on defaulters?

-what happens when one defaults?

How do you keep records of patients on PEP?

What algorithm/guidelines do you follow in dispensing of drugs?

Stocking

What methodology do you use to stock your drugs?

Where do you get your drugs from?

Have you received any training on post rape care management to defiled children?

Challenges

What challenges do you experience in your line of work?

Institutional support

How has the institution supported in you to enable you work well?

What more support should the institution provide for you to work well?

Appendix 3: Thematic interview guide for health providers (lab tech)

Personal background information

Profession:

Health facility:

Education/ Qualification:

Understanding of terms used in the Kenya sexual Offences ACT and Kenya national guidelines on Management of Child Sexual Abuse

What's your definition of a child?

How do you define child sexual abuse?

How do you define child defilement?

What's your definition of post rape care?

What's your definition of emergency contraception?

Perceptions on causes and consequences of child sexual abuse

What role do you play as a lab technician in delivery of post rape care?

How would you rate the occurrence of child defilement cases in the community?

Who would you say are the main perpetrators of sexual abuse in this community?

In your opinion what makes children in this community vulnerable to sexual abuse?

Do you think some sexually abused children are to blame for being sexually abused? Why?

Skills and training

What trainings have you undergone to capacity build you on delivery of post rape care to children?

Lab work

What kind of test do you carry out for defiled children?

What laboratory equipment is available for collected sample testing?

How do you keep records of tests and samples taken in the lab for defiled minors?

How do you ensure confidentiality and security of patients and samples respectively?

What's chain of evidence?

How do you maintain the chain of evidence?

Challenges

What challenges do you experience in your line of work when delivering PRC?

Institutional support to avoid burnout among employees

What support has the institution given to enable you deliver post rape care to children?

What more support do you think the institution should provide to enable you work

Appendix 4: Thematic interview guide for health providers (counsellors)

Personal background information

Profession:

Health facility:

Education/ Qualification:

Understanding of terms used in the Kenya sexual Offences ACT and Kenya national guidelines on Management of Child Sexual Abuse

What's your definition of a child?

How do you define child sexual abuse?

How do you define child defilement?

What's your definition of post rape care?

What's your definition of emergency contraception?

Counselling sessions

What role do you play in delivery of post rape care?

What preparations do you put in place before starting a counselling session?

Please take me through the defiled patient counselling process?

Whom do you counsel?

What types of counselling do you give?

Defaulting – where patients were going to?

How many lessons do defiled patients have to go through in trauma counselling?

Rights of patients

What rights is the defiled patient entitled to?

How do you ensure these rights are met?

Supervision and therapy

Do you receive support supervision?

Referrals

Who are the partners that you work with?

Challenges

What challenges do you experience in your line of work?

Institutional support

How has the institution supported in you to enable you work well?

What more support should the institution provide for you to work well?

Appendix 5: Thematic interview guide for health providers (health records officer)

Personal background information

Profession:

Health facility:

Education/ Qualification:

Understanding of terms used in the Kenya sexual Offences ACT and Kenya national guidelines on Management of Child Sexual Abuse

What's your definition of a child?

How do you define child sexual abuse?

How do you define child defilement?

What's your definition of post rape care?

What's your definition of emergency contraception?

Data management

What role do you play in delivery of post rape care?

Please take me through the defiled patient data management process?

How do you ensure that the files are secure?

Challenges

What challenges do you experience in your line of work?

Institutional support

How has the institution supported in you to enable you work well?

What more support should the institution provide for you to work well?

Appendix 6: Informed consent sheet for health providers

My name is *Cynthia Wangamati* and I am a researcher and a student from the University of Oslo in Norway. This is a request for you to participate in a research study where the objective of the study is to assess the quality of post rape care given to sexually abused children. For me to do this, I have to hold a discussion with you.

I am interested in your role and perceptions as a health provider in provision of post rape care to sexually abused children. I would like to know more about the training that the institution has offered you to prepare you for provision of post rape care. I would also like to know your opinion and experiences on challenges you face in provision of post rape care to sexually abused children.

Procedures to be followed

The interview may take approximately 1 hour. I will ask you different questions, and I will take notes while we talk. If you are uncomfortable with a question, you don't have to answer it. With your permission, I will use a tape recorder to record the conversation so that I will not forget what we have discussed. You can end the interview any time you wish. I might ask you to meet me with you again for another interview to seek clarification on things I may have not understood and ask you some more questions that I may not have time to ask.

Discomforts and Risks

Questions asked are on a sensitive topic and they may be embarrassing and hence make you uncomfortable. If this happens you have a right to refuse to answer the question or stop the whole interview.

Benefits

Your participation in the study will help us gain information on the quality of post rape care provided by the health facility. This information will be given as feedback to the health facility management in the hopes that it will be used to improve post rape care services offered to minors.

Reward

If you agree to participate you will be given Kshs.200 to cater for lunch.

Confidentiality

The information you share during the interview is confidential. I will assure confidentiality by not writing down your name or other identifiable information. All written information from this interview will be given a number instead of your name. Any other information that may come up during the discussion that may make you identifiable will be changed.

After we have finished this conversation, nobody will have access or listen to what we have discussed here apart from the research team. All the tapes and written information from this interview will be kept in a locked cabinet in my house where only I have access. I will also have to share my findings from this study for purposes of completion of my master's degree.

Voluntary participation

Appendix 7: Informed consent form for adolescents

My name is *Cynthia Wangamati* and I am a researcher and a student from the University of Oslo in Norway. This is a request for you to participate in a research study where the objective of the study is to assess the quality of post rape care given to sexually abused children. For me to do this, I have to hold a discussion with you. Your participation in this study will enable me to gain information on the quality of post rape care service provision. Hopefully this feedback will enable health facility management to improve their post rape care services.

I am interested in your experiences of post rape care you received from the health facility. The things you liked about the treatment and what you didn't like about the treatment. I would also like to know the challenges that you went through while receiving the care.

Procedures to be followed

The interview may take approximately 1 hour. I will ask you different questions, and I will take notes while we talk. If you are uncomfortable with a question, you don't have to answer it. With your permission, I will use a tape recorder to record the conversation so that I will not forget what we have discussed. You can end the interview any time you wish. I might ask you to meet me with you again for another interview to seek clarification on things I may have not understood and ask you some more questions that I may not have time to ask.

Discomforts and Risks

Questions asked are on a sensitive topic and they may be embarrassing and hence make you uncomfortable. If this happens you have a right to refuse to answer the question or stop the whole interview.

Benefits

Your participation in the study will help us gain information on the quality of post rape care provided by the health facility. This information will be given as feedback to the health facility management in the hopes that it will be used to improve post rape care services offered to minors.

Reward

If you agree to participate you will be reimbursed Kshs. 200 to cover your travel expenses.

Confidentiality

The information you share during the interview is confidential. I will assure confidentiality by not writing down your name or other identifiable information. All written information from this interview will be given a number instead of your name. Any other information that may come up during the discussion that may make you identifiable will be changed.

After we have finished this conversation, nobody will have access or listen to what we have discussed here apart from the research team. All the tapes and written information from this interview will be kept in a locked cabinet in my house where only I have access. I will also have to share my findings from this study for purposes of completion of my master's degree.

Voluntary participation

Participation in the study is voluntary. You can withdraw anytime from the study any time you want without giving reason. Your child will get the same care and medical treatment from the

Appendix 8: Ethics approval Kenya and Norway



KENYATTA UNIVERSITY ETHICS REVIEW COMMITTEE

Fax: 8711242/8711575
Email: kuerc.chairman@ku.ac.ke
kuerc.secretary@ku.ac.ke
Website: www.ku.ac.ke

P. O. Box 43844
Nairobi, 00100
Tel: 8710901/12
Tel: 8710901/12

Our Ref: KU/R/COMM/51/223

Date: 23rd September, 2013

Ms. Cynthia K. Wangamati
University of Oslo
Institute for General Practice and Community Medicine
Section for International Community Health
P. b 1130 Blindern, 0370 Oslo, NORWAY

Dear Ms. Wangamati,

APPLICATION NUMBER PKU/146/E 18 OF 2013 – “QUALITY OF POST RAPE CARE GIVEN TO SEXUALLY ABUSED MINORS IN HOMABAY COUNTY, KENYA” – Version 2

1. IDENTIFICATION OF PROTOCOL

The application before the committee is with a research topic “Quality of post rape care given to sexually abused minors in Homabay County, Kenya” dated 23rd September, 2013.

2. APPLICANT

Ms. Cynthia K. Wangamati
University of Oslo
Institute for General Practice and Community Medicine
Section for International Community Health
P. b 1130 Blindern, 0370 Oslo, NORWAY

3. SITE

Homabay County, Kenya

4. DECISION

The committee has considered the research protocol in accordance with the Kenyatta University Research Policy (section 7.2.1.3) and the Kenyatta University Ethics Review Committee Guidelines, and is of the view that against the following elements of review,

- (i) Scientific design and conduct of study,
- (ii) Recruitment of research participant,
- (iii) Care and protection of research participants,
- (iv) Protection of research participant’s confidentiality,
- (v) Informed consent process,
- (vi) Community considerations.

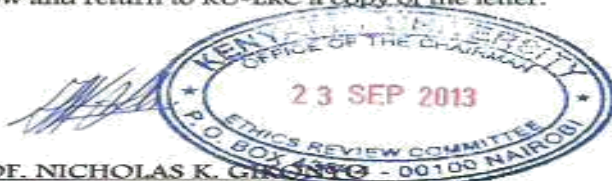
AND APPROVED that the research may proceed for a period of ONE year from 23rd September, 2013

5. ADVICE/CONDITIONS

- i. Progress reports are submitted to the KU-ERC every six months and a full report is submitted at the end of the study.
- ii. Serious and unexpected adverse events related to the conduct of the study are reported to this board immediately they occur.
- iii. Notify the Kenyatta University Ethics Committee of any amendments to the protocol.
- iv. Submit an electronic copy of the protocol to KUERC.

When replying, kindly quote the application number above.

If you accept the decision reached and advice and conditions given please sign in the space provided below and return to KU-ERC a copy of the letter.



PROF. NICHOLAS K. GIKUNDO
CHAIRMAN ETHICS REVIEW COMMITTEE

I Agatha Kharela Wangarati..... accept the advice given and will fulfill the conditions therein.

Signature..... Danga..... Dated this day of 24/09/..... 2013.

cc. Vice-Chancellor
DVC: Research, Innovation and Community Outreach,
Director: Institute for Research Science and Technology

ETHICS APPROVAL NORWAY



Region: REK sør-øst	Officer: Jakob Elster	Phone: 22845530	Our date: 28.06.2013	Reference: 2013/1047/REK sør-øst B
			Your date: 28.05.2013	

To Johanne Sundby

2013/1047 Quality of Post Rape Care given to sexually abused children in rural Kenyan hospitals

Institution responsible: University of Oslo

Chief Investigator: Johanne Sundby

In reference to your application reviewed by the Committee on the 12th of June 2013.

Project description

The aim of the study is to assess the quality of post rape care to survivors of child sexual abuse in Kenya. Victims of sexual violence require comprehensive post rape care to enable them to deal with the negative health effects and also seek justice against the perpetrators through forensic examination. Post rape care reduces the risk of contracting STIs, HIV infection, unwanted pregnancies and psychological morbidities. A combination of methods will be used: 1. Review of existing medical files: The medical files will be reviewed in order to examine the procedures involved in the seeking of informed consent, history taking and physical examination. Permission will be sought from the Kenyan ethical committee in order to access the files without the consent of the patients, as it might be difficult to access the patients. 2. In depth interviews: semi structured interviews with open ended questions in line with the study objectives will be carried out with 6 health providers and 12 caregivers to children who have experienced sexual abuse. 3. Observational methods: Structured observation of the minimum requirements that the facility should meet if they are providing post rape care services using a checklist from the World health organization. Additionally, direct observation of patients seeking post rape care will be carried out at the emergency section and other areas where the patients will be referred to. 4. Case studies: Two adolescents will be interviewed and followed up prospectively when they come to the health facilities to seek post rape care services. The participants will be adolescents over the age of 12 who have experienced sexual abuse. Consent will be sought from the children, caregivers and health providers who will be interviewed.

The committee's assessment

The committee finds the research project important and useful.

The main ethical challenge of the project concerns the possible psychological stress which the adolescent children might suffer as a result of the interview. However, counsellors will be present during the interview to advice on how the interview should proceed and to offer counselling services. The committee finds this measure satisfactory. The committee would also like to underline that it is the project leader's responsibility to ensure that the interviews are carried through in a defensible manner and that the student who will perform the interviews receives the necessary guidance.

The committee's approval is dependent on the project receiving the necessary ethical approval from the Kenyan ethical committee.

The committee's decision

The project is approved.

The approval is valid until 31.12.2013. The data must be stored as de-identified data, i.e. with identifying information kept separate from the other data. For purposes of documentation, the data shall be kept until 31.12.2018, and deleted or anonymized after this date.

The data must be stored in accordance with the norms of data protection in personopplysningsforskriften chapter 2, and the guide "Personvern og informasjonssikkerhet i forskningsprosjekter innenfor helse- og omsorgssektoren", published by the Norwegian Directorate of Health.

If the project manager wants to make substantial changes to the objective, method, schedule or organisation of the research project, an application must be submitted to the Regional Committee for Medical and Health Research Ethics. The project manager must submit a final report to the Regional Committee for Medical and Health Research Ethics when the research project is finished.

The decision of the committee may be appealed to the National Committee for Research Ethics in Norway. The appeal should be sent to the Regional Committee for Medical and Health Research Ethics in Norway, South-East B. The deadline for appeals is three weeks from the date on which you receive this letter.

Med vennlig hilsen

Stein Opjordsmoen Iler
Prof. dr. med
Chair of the Regional Committee for
Medical Research Ethics of Southern Norway (P.P) Section B

Jakob Elster advisor

Copy: johanne.sundby@medisin.uio.no; universitetsdirektor@uio.no