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Delivering post-rape care services

Delivering post-rape care services: Kenya's experience in developing integrated services

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Une traduction en français de ce résumé figure à la fin de l'article. Al final del artículo se facilita una traducción al español. المقالة لهذه الكامل النص نهاية في الخلاصة لهذه العربية الترجمة.

ABSTRACT

Problem: Comprehensive service delivery models for providing post-rape care are largely from resource-rich countries and do not translate easily to resource-limited settings such as Kenya, despite an identified need and high rates of sexual violence and HIV.

Approach: Starting in 2002, we undertook to work through existing governmental structures to establish and sustain health sector services for survivors of sexual violence.

Local setting: In 2003 there was a lack of policy, coordination and service delivery mechanisms for post-rape care services in Kenya. Post-exposure prophylaxis against HIV infection was not offered.

Relevant changes: A standard of care and a simple “post-rape care systems algorithm” were designed. A counselling protocol was developed. Targeted training that was knowledge-, skills- and values-based was provided to clinicians, laboratory personnel and trauma counsellors. The standard of care included clinical evaluation and documentation, clinical management, counselling and referral mechanisms. Between early 2004 and the end of 2007, a total of 784 survivors were seen in the 3 centres at an average cost of US \$25, with numbers increasing each year. Almost half (43%) of these were children aged less than 15.

Lessons learned: This paper describes how multi-sectoral teams at district level in Kenya agreed that they would provide post-exposure prophylaxis, physical examination, sexually transmitted infection and pregnancy prevention

services at casualty departments and through voluntary HIV counselling and testing sites. It outlines what considerations they took into account, who accessed services and how the lessons learned were translated into national policy and scale-up of post-rape care services through the key involvement of the Department of Reproductive Health.

Introduction

Sexual violence is increasingly documented in Kenya but only limited post-rape care services exist.^{1,2} Survivors of sexual violence experience complex needs³ and many countries have developed one-stop facilities that enable survivors to access medical, legal and social support services.⁴⁻⁶ These do not translate easily to the resource-poor Kenyan setting.⁷ This paper summarizes the context of the Kenyan health system, presents findings from a situation analysis on post-rape care conducted in 2002 and outlines the lessons learned from the subsequent implementation of services in 3 district hospitals in Kenya between 2003 and 2007.

Kenyan context

The Kenyan government health system operates an integrated (sometimes termed “horizontal”) approach to primary care.⁸ The over-arching responsibility for policy and capacity development in the delivery of post-rape care services lies centrally with the government’s Division of Reproductive Health. It functions through provincial and district systems, where the District Health Management Teams are the primary unit of planning and managing post-rape care in health facilities.⁹ Alongside this, programmes for sexually transmitted infections (STIs) and HIV testing are supervised and managed nationally (a “vertical” approach). If survivors of sexual violence are to access the range of basic services they require, existing links between vertical and horizontal programmes involved in post-rape care require strengthening (Table 1).^{10,11} Links with the judiciary in Kenya are weaker still, compounding difficulties faced by the health sector in the collection, analysis and delivery of evidence to the justice system.

A situation analysis in 2003 revealed limited post-rape services, lack of policy and tensions between HIV and reproductive health staff at service delivery points.¹² Facilities lacked protocols and confidential spaces for treatment. Beyond a requirement that examinations be undertaken by a doctor, there were no reporting requirements and an absence of monitoring and evaluation of services. Furthermore, survivors were required

to pay for drugs and services in public institutions. Where HIV-test counselling existed, it was delivered in the context of voluntary counselling and testing (VCT). Formal counselling for sexual trauma, where it existed, did not give consideration to HIV testing.

System development process

First a standard of care was developed in selected districts. In collaboration with a Kenyan nongovernmental organization (Liverpool VCT, Treatment and Care) services were established in government health facilities in 3 disparate districts in 2003 (Thika, Malindi and Rachuonyo) with the aim of informing national policy directly with experiences from the field. Consultation workshops were hosted with the District Health Management Teams to develop consensus and create ownership. Each team assigned the coordination of post-rape care services to an individual member, who then liaised with the local police to ensure immediate referral of survivors to health facilities. The services were advertised through existing public health systems and wider staff training. A standard of care was agreed for the selected districts and protocols for physical examination, legal documentation and clinical management were drawn from this. A simple algorithm and clearly defined client flow pathway, summarized in a job aide, improved triage and facilitated access to the range of service delivery points (Fig. 1).

The first port of call for survivors was the casualty (emergency) department, open 24 hours a day, where physical examination was conducted by a doctor, records kept and further referrals made. Emergency contraception, empirical STI treatment and starter packs of a two-drug HIV post-exposure prophylaxis (PEP) regimen¹³ were kept in casualty as part of essential drugs and offered routinely to survivors on presentation. To facilitate the collection of evidence, a locally assembled “post-rape” kit was supplied by the district’s sterilizing and surgical department. It included gloves, swabs and plastic bags, glass slides for preparing specimen mounts, sanitary pads and a speculum. Police signed for any specimens they removed from casualty thus initiating a chain of custody of evidence. Data was captured by registers on the history of the alleged assault, therapies provided and specimens collected. After referral from casualty, post-rape counselling services were provided in the VCT sites; laboratory staff documented the results of HIV and other testing; and HIV care clinic staff prescribed and documented on-going PEP.

Two separate peer-reviewed training programmes were piloted in the districts and are available for use in other settings.¹³ A core element of both was the exploration of attitudes around gender, abuse and sexuality. A 3-day training course aimed at all types of frontline clinicians involved in post-rape care included skills for clinical evaluation, risk assessment¹³ and legal documentation. The other longer course targeted practicing HIV counsellors from the facilities and focused on skills and observed practice for trauma counselling, HIV testing after rape, PEP adherence and legal information.

Initial challenges

All 3 districts experienced significant challenges in implementing the new services, many of which related to the lack of coordination between vertical and horizontal systems. For example, Thika and Rachuonyo district hospitals were unable to prescribe empirical STI treatment from existing stocks until new systems for reporting were developed that did not directly link drug supply to screening results. The majority of clinicians felt that they were not ready to deliver evidence in court and were reluctant note-takers. Poor referral mechanisms from the smaller health facilities to the 3 district hospitals and within the hospitals themselves were associated with losses to follow up, out-of-pocket costs to survivors and poor coordination of services.

Counsellors also experienced uncertainty around shared confidentiality: 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. Currently, the lack of a cadre of counsellors in the Kenyan government system has hampered post-rape care. Many health-care workers end up doing HIV testing and also trauma counselling in addition to their normal duties. This translates into provider stress, high attrition rates and inconsistent service delivery that challenge the investment in capacity building described in this paper.

Uptake of services and client satisfaction

By the end of 2007 a total of 784 survivors of sexual violence had been seen in the 3 sites, with 43% of them young people (predominantly girls) aged less than 15. Of these 84% arrived in time to be eligible for PEP. There was one known seroconversion of a previously HIV-negative girl, who had reported repeated abuse by an uncle. Client exit

interviews conducted with survivors or their guardians in 2005 indicate a high level of satisfaction with the services. No information on prosecution and conviction rates of perpetrators are available but anecdotally these are very low.

Using district lessons to inform policy

In mid 2004, the Kenyan Division of Reproductive Health disseminated the findings of the situation analysis¹² and the interventions and challenges described above, including the high numbers of paediatric presentations. The high paediatric uptake is likely to represent a reflection of the social constructs around rape in Kenya, which may cause the blame for sexual violence to be put on the adult survivors but sees children as victims.¹² A committee was constituted and national guidelines for the medical management of rape and sexual violence¹⁴ approved and disseminated in 2005, with the Division of Reproductive Health recommending user-fees be waived. 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. The training curricula were peer-reviewed and approved as the national manuals in 2006. Since 2006, indicators for post-rape care, including the number of health-care workers trained, the number of health facilities offering services, percentage of police officers trained and the percentage of antiretroviral treatment sites offering post-rape care, have been incorporated in national planning. This has ensured annual reporting and appropriate assignment of resources for purchase of emergency contraception and PEP. By June 2007, there were 13 health facilities providing post-rape care services in Kenya including the national referral and teaching hospital. Between them they had delivered services to over 2000 adults and children with 96% of those eligible initiating PEP at presentation.

A formal costing of the services, undertaken between June 2005 and July 2006, revealed that laboratory tests (28%), antiretroviral drugs for PEP (25.7%), cost of staff (23%) and hepatitis B toxoid (6.9%) were the main expenditures. The cost of providing post-rape care services for females or males at the district hospital level were estimated at \$US 27 per patient, in line with other new services such as HIV counselling and testing.¹⁵

The potential to improve relationships between the health sector and justice systems has not been realized in Kenya. Specimen collection of sufficient standard to

provide evidence in court was undermined by the lack of commercial specimen collection kits or availability of additional requirements such as tamper evidence seals, replacement clothing and specula suitable for children. In addition there was a lack of DNA profile testing. We were unable to determine how many of the survivors received legal support nor the role played by the evidence that was collected. This remains a practical and policy gap in the provision of post-rape care.

Conclusion

Kenya has seen a rapid policy response to the documented need for post-rape care services among both adult and child survivors. Key lessons learned (Box 1) were: the importance of a participatory policy development process; the central role of political commitment in overcoming tensions between vertical and horizontal programmes; and the flexibility to develop creative solutions at local level where paediatric uptake is high. The processes described in this paper are replicable in other settings and we look forward to further sharing our experience in this neglected area.

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Competing interests:

None declared.

References

1. Mensch BS, Hewett P, Erulkar A. The reporting of sensitive behaviour among adolescents: a methodological experiment in Kenya. *Demography* 2003;40:247-68. PMID:12846131 doi:10.1353/dem.2003.0017
2. Speight CG, Klufio A, Kilonzo SN, Mbugua C, Kuria E, Bunn JE, et al. Piloting post-exposure prophylaxis in Kenya raises specific concerns for the management of childhood rape. *Trans R Soc Trop Med Hyg* 2006;100:14-8. PMID:16225898 doi:10.1016/j.trstmh.2005.06.026
3. *Guidelines for medico-legal care of victims of sexual violence*. Geneva: World Health Organization; 2003.

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Article DOI: 10.2471/BLT.08.052340

4. Kerr E, Cottee C, Chowdhury R, Jawad R, Welch J. The Haven: a pilot referral centre in London for cases of serious sexual assault. *BJOG* 2003;110:267-71. PMID:12628265 doi:10.1046/j.1471-0528.2003.02233.x
5. Kim JC, Martin LJ, Denny L. Rape and HIV post-exposure prophylaxis: addressing the dual epidemics in South Africa. *Reprod Health Matters* 2003;11:101-12. PMID:14708401 doi:10.1016/S0968-8080(03)02285-7
6. Goldberg AP, Duffy SJ. Medical care for the sexual assault victim. *Med Health R I* 2003;86:390-4. PMID:14983541
7. Garcia-Moreno C. Dilemmas and opportunities for an appropriate health-service response to violence against women. *Lancet* 2002;359:1509-14. PMID:11988263 doi:10.1016/S0140-6736(02)08417-9
8. Smith DL, Bryant JH. Building the infrastructure for primary health care: an overview of vertical and integrated approaches. *Soc Sci Med* 1988;26:909-17. PMID:3388071 doi:10.1016/0277-9536(88)90411-X
9. Oyaya CO, Rifkin SB. Health sector reforms in Kenya: an examination of district level planning. *Health Policy* 2003;64:113-27. PMID:12644333 doi:10.1016/S0168-8510(02)00164-1
10. Watts C, Mayhew S. Reproductive health services and intimate partner violence: shaping a pragmatic response in sub-Saharan Africa. *Int Fam Plan Perspect* 2004;30:207-13. PMID:15590387
11. Oliveira-Cruz V, Kurowski C, Mills A. Delivery of priority health services: Searching for synergies within the vertical versus horizontal debate. *J Int Dev* 2003;15:67-86. doi:10.1002/jid.966
12. Kilonzo N, Taegtmeier M, Molyneux S, Kibaru J, Kamonji V, Theobald S. Engendering health sector responses to sexual violence and HIV in Kenya: Results of a qualitative study. *AIDS Care* 2008;20:188-90. PMID:18293127 doi:10.1080/09540120701473849
13. Garcia MT, Figueiredo RM, Moretti ML, Resende MR, Bedoni AJ, Papaiordanou PM. Postexposure prophylaxis after sexual assaults: a prospective cohort study. *Sex Transm Dis* 2005;32:214-9. PMID:15788918 doi:10.1097/01.olq.0000149785.48574.3e
14. Ministry of Health/Division of Reproductive Health. National guidelines on the medical management of rape/sexual violence. Nairobi: Tonaz Agencies; 2004. Available from: http://www.drh.go.ke/html/guidelines_Gender.asp [accessed on 20 February 2009].
15. Forsythe S, Arthur G, Ngatia G, Mutemi R, Gilks C. Assessing the cost of voluntary counselling and testing in Kenya. *Health Policy Plan* 2002;17:187-95. PMID:12000779 doi:10.1093/heapol/17.2.187

Box 1: Summary of lessons learned

- The importance of a participatory policy development process
- The central role of political commitment in overcoming tensions between vertical and horizontal programmes
- Flexibility to develop creative solutions at local level where paediatric uptake is high

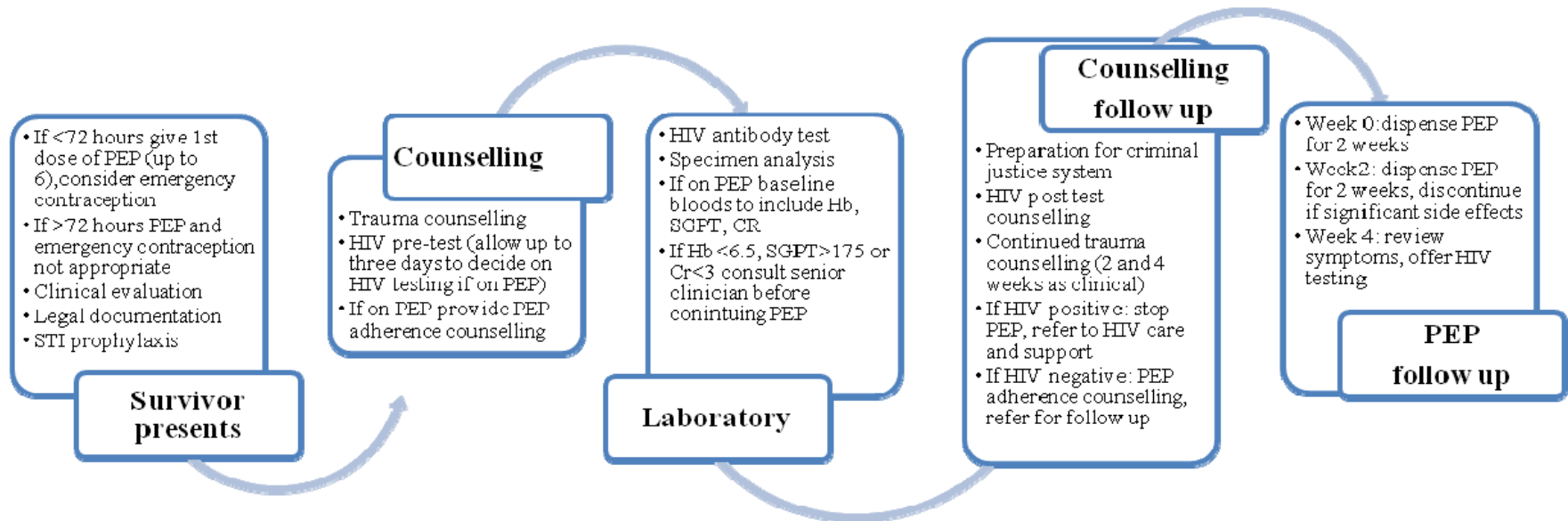
Table 1. Location and service delivery module for post-rape care services in Kenya

Service required	Department responsible	Service delivery location in Kenyan district hospitals	Predominant service delivery mode in Kenya
Injuries management	—	Casualty	Horizontal
Legal documentation	—	Examining medical officer	Horizontal
Laboratory services (specimen analysis)	National Reference Laboratories	Local laboratory	Horizontal
HIV testing	National laboratories/NASCOP	Local laboratory	Vertical
Emergency contraception	Division of Reproductive Health	Maternal & Child Health/Family Planning	Horizontal
Counselling services (related to HIV)	National AIDS and STI Control Programme	Voluntary counselling and testing sites	Vertical
Counselling services	Mental Health Services	Diagnostic counselling sites	Horizontal
HIV PEP	National AIDS and STI Control Programme	HIV care clinics	Vertical
STI prophylaxis	National AIDS and STI Control Programme/ Division of Reproductive Health	STI clinics	Vertical/horizontal ^a
Data and records management	Ministry of Health Monitoring and Evaluation Unit	District Health Records Information Office	Integrated health management information system

NASCOP, National AIDS/STI Control Programme; PEP, post-exposure prophylaxis; STI, sexually transmitted infection.

^a Since 2006 STI treatment has been conducted through a horizontal approach.

Fig. 1. Post-rape care services algorithm developed for health facilities in Kenya



CR, creatinine; Hb, haemoglobin; PEP, post-exposure prophylaxis; SGPT, serum glutamic pyruvic transaminase; STI, sexually transmitted infection.