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**Pathways of care for sexual violence survivors and the benefits
and drawbacks of using community health workers to provide
support health services to sexual violence survivors: A systematic
review and case study in Kenya**

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Statement of Own Work

I, Anne Gatuguta, declare that I have read and understood the School's definition of plagiarism and cheating given in the Research Degrees Handbook. I declare that this thesis is my own work, and that I have acknowledged all results and quotations from the published or unpublished work of other people.

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Abstract

Background: Research shows that sexual violence is widespread and has multiple adverse health consequences. Globally, majority of sexual violence survivors either do not access care or access care late. Many of those who access care are lost to treatment follow-up before they can fully realise the benefits of medical care. Evidence suggests that community health workers (CHWs) have the potential to improve healthcare for survivors. There is limited data however, on how to deliver these services effectively.

Aim: To explore sexual violence survivors' experience of seeking healthcare and experiences through the continuum of care in Kenya; and, to understand the benefits and drawbacks of using CHWs to provide support health services to sexual violence survivors.

Methods: A mixed methods approach was used: 1) a systematic literature review of CHWs services for sexual violence to explore the existing models of services as well as the benefits and drawbacks; 2) records for 543 survivors were reviewed and key informant interviews conducted with healthcare providers in two referral hospitals. These hospital data were compared with national-level data on survivors from the Kenya Demographic and Health Survey 2014, and the Violence Against Children Survey 2010; 3) survivors were interviewed on their care pathways, current experience of services, perceived health service's needs and experience of CHWs services; 4) CHWs, healthcare workers and other stakeholder's with expertise in providing care for sexual violence were interviewed on their experiences and views on CHWs services for sexual violence.

Results: There are multiple barriers to healthcare and missed treatment opportunities for survivors, both at the community and hospital level. Children, men, partnered or ever-partnered survivors and survivors experiencing violence from intimate partners are more likely to miss treatment. CHWs are already involved in sexual violence healthcare pathways carrying out awareness creation, identifying survivors, linking survivors to care and providing psychosocial support. However, training, better definition of roles and support from the healthcare system is needed.

Conclusions: This thesis has identified specific barriers to services for sexual violence survivors and specific groups at risk of missing treatment. CHWs can form a part of interventions aimed to address the current barriers to treatment; however, more research is required to inform designing the models of services.

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List of Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BMC	BioMed Central
CCC	Comprehensive Care Clinic
CD4	Cluster of Differentiation 4
CHEW	Community Health Extension Worker
CSA	Child Sexual Abuse
CHWs	Community Health Workers
CO	Clinical Officer
EC	Emergency Contraceptive
EPHPP	Effective Public Health Practice Project
GBV	Gender Based Violence
GVRC	Gender Violence Recovery Centre
HCP	Healthcare Provider
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
IPV	Intimate Partner Violence
KDHS	Kenya Demographic and Health Survey
LSHTM	London School of Hygiene and Tropical Medicine
LVCT	Liverpool Voluntary Counselling and Testing Care and Treatment
MOH	Ministry of Health
NGO	Non-Governmental Organisation
NICE	National Institute for Health and Clinical Excellence
PEP	Post Exposure Prophylaxis
PRC	Post Rape Care
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
PROSPERO	International Prospective Register of Systematic Reviews
SGBV	Sexual and Gender Based Violence
STI	Sexually Transmitted Infection
TB	Tuberculosis
VACS	Violence Against Children Survey
VDRL	Venereal Disease Research Laboratory

WHO World Health Organisation
WKF Wangu Kanja Foundation

Definition of terms

Child: Anyone under the age of 18 years.

Child sexual abuse: 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.

Community health worker: A community-based worker who has received limited training but is not trained as a professional health worker, who is a member of the community where he/she works, who is selected by his/her community, and is supported by the health system but is not necessarily a part of its organisation.

Healthcare provider: A health-care professional who is trained and knowledgeable in health (includes nurses, clinical officers, counsellors, doctors).

Intimate partner: Refers to a current or past sexual partner e.g. spouse, cohabiting partner, boyfriend etc.

Sexual violence: Any sexual act, attempts to obtain a sexual act, unwanted sexual comments or advances, trafficking using coercion by any person regardless of their relationship to the victim, in any setting. These include rape, attempted rape, gang rape, defilement and incest among others.

Survivor: Anyone who has experienced sexual violence.

Chapter 1: Introduction

In Kenya, sexual violence is a major health problem with national survey data showing that up to 14% of women and 6% of men report ever having experienced sexual violence [1]. Among children, girls report sexual violence more commonly than boys with 32% of females and 18% of males reporting experiencing sexual violence before the age of 18 years [2]. The high prevalence of sexual violence reported in children is inconsistent with the lifetime prevalence in adults suggesting reporting differences between adults and children. In spite of the fact that post rape care services are available in government health facilities throughout the country, more than 90% of those who experience sexual violence do not seek healthcare [1, 2]. Additionally, more than 50% of those who seek care are lost to follow-up within 4 weeks and less than 40% of those who start treatment complete the 28-day human immune-deficiency virus (HIV) post exposure prophylaxis (PEP) treatment course [3-5].

There has been limited research in Kenya on the reasons why many survivors do not seek healthcare or complete treatment. However, a few qualitative studies with community members and health care workers, highlight stigma as well as social norms that tend to normalise sexual violence or blame the survivor [6, 7]. Moreover, these studies also point out multiple other individual, community and health system factors that together account for the fact that most survivors do not disclose the violence or seek treatment. For instance, interviews with community members living in the vicinity of health facilities providing post-rape services indicated that many of them lacked knowledge on the importance of seeking care and/or the existence of such care [7]. This study also found that lack of a clear understanding of what constitutes sexual violence such as cultural norms that do not recognise marital rape, a culture where men believe that “girls say no when they mean yes” also hindered treatment seeking. Being stigmatised, blamed for the sexual violence and being subjected to insensitive treatment by service providers were also significant barriers to care seeking [6].

Attrition of survivors during the care process occurs in several areas. During the initial visit, attrition may occur during referral between different departments or different health facilities [5, 8]. For instance, in most facilities, HIV comprehensive care centres (CCC) where HIV PEP is provided and counselling departments are not open at night and during weekends, therefore, survivors who present at these times are expected to return for services offered in these departments and some of these survivors do not return. In facilities where only some services are available and survivors require to be referred to more equipped facilities, a proportion of survivors are lost during this transition [8]. However, the highest proportion of attrition most frequently occurs during the follow-up period and no mechanisms exist to trace the survivors.

Given the importance of treatment and the obvious failure of many survivors to access healthcare and complete treatment, it is important to understand the experiences of survivors in accessing healthcare and barriers along the healthcare pathways. Additionally, it is necessary to understand which survivors are more likely to miss healthcare and to explore alternative routes of reaching these survivors, particularly at the community level. This study therefore had four main objectives:

1. To understand the benefits and challenges of using community health workers (CHWs) to provide support services for sexual violence survivors in diverse settings
2. To describe the characteristics of sexual violence survivors and healthcare services provided in Kenya
3. To explore the experiences of sexual violence survivors in seeking and receiving care, and the role of CHWs in the care pathways
4. To explore CHWs and other stakeholders' views and experiences on delivering support health services to sexual violence survivors in Kenya and the acceptability and feasibility of CHWs services

1.1 Structure of the thesis

This thesis is presented in eight chapters: six book-style and two paper-style chapters. The papers and the other chapters are closely related (hence some overlap was

inevitable particularly in the background and methods) and linking material between the chapters is provided.

Chapter 2 provides a background on sexual violence, healthcare for sexual violence survivors and CHWs services, with a particular focus on Kenya. A conceptual framework upon which this study was conducted is also presented.

Chapter 3 describes the overall methodology used for the study and includes overall study design; study location; a description of the systematic review, the quantitative and qualitative data methods; and the ethical considerations during the conduct of the study. The specific methods applicable to particular chapters are described in the respective chapters.

Chapter 4 is written as a paper and presents a systematic review of CHWs services for sexual violence globally. This chapter reports findings suggesting that involving CHWs in sexual violence services may be beneficial, however, research on these services was limited and therefore a need for further research to establish survivor's views on these services and the effectiveness of these services was identified.

Chapter 5 is written as a paper and presents the results of the facility-based quantitative analysis of the characteristics of survivors seeking healthcare and the services provided at hospitals in Kenya. It compares and contrasts these findings with two national survey data on survivors reporting violence nationally to identify specific groups of survivors missing out on treatment. Qualitative data collected from interviews with healthcare providers (HCPs) provide more insight into the characteristics of survivors and the challenges of providing services to survivors.

Chapter 6 describes the pathways of healthcare for survivors of sexual violence in Kenya. It draws from qualitative data collected from survivors on their experiences of seeking healthcare tracing their trajectory from the time of violence, disclosure, their experience of services received, follow-up and their perceptions on further services

they need. Both survivors who sought healthcare and survivors who did not seek healthcare provide insight into the barriers to seeking and completing treatment.

Chapter 7 summarises data from survivors, CHWs, healthcare providers and other stakeholders to describe the roles of CHWs in sexual violence services in Kenya. It also describes the barriers and facilitators of these services.

Chapter 8 integrates the findings from the different sources in order to draw conclusions and recommendations on healthcare services for survivors in Kenya and use of CHWs in these services.

Chapter 2: Background

2.1 Global prevalence of sexual violence and recommended healthcare for survivors

Current research indicates that intimate partner and non-partner sexual violence is widespread globally. Prevalence varies from region to region with population-based studies indicating that between 6% and 59% of women report experiencing intimate partner sexual violence and up to 12% report non-partner sexual violence [9-12]. Although data are limited, males are also affected. In children, girls are more commonly affected than boys, with up to 38% of girls and 23% of boys having experienced sexual violence during childhood [13, 14]. Due to limited data available, and considerable underreporting, the true magnitude of sexual violence is unknown but likely higher than these figures [15].

Sexual violence is associated with significant health risks both in the short-term and long-term [9, 10, 12, 16]. The World Health Organisation (WHO) recommends that sexual violence survivors should receive treatment immediately and be followed for up to six months [17]. Trauma-related mental health status, physical injuries [18], the risk of HIV and other sexually transmitted infections (STIs) acquisition [19-21] and the risk of unwanted pregnancies [19, 20] are of particular immediate concern. In the long-term, there are mental health [19, 20, 22, 23], behavioural [23], sexual and reproductive health complications [18, 20]. In view of these adverse consequences, immediate and long-term health care is paramount. Yet globally, studies show that the majority of sexual violence survivors either do not access care, access care late or are lost to treatment follow-up before they can fully realise the benefits of medical care [3, 19, 24-26].

The recommended immediate care for a survivor consists of medical attention to any physical injuries, provision of emergency contraception, collection of specimens for both medical and legal purposes, psychosocial counselling as well as documentation of the violence [17, 27]. Where indicated, the provision of prophylaxis particularly for HIV/STIs and for pregnancy in women is critical and time-dependent. WHO

recommends HIV PEP should be given as soon as possible and within 72 hours of exposure and taken for at least 28 days [15, 17, 21]. Emergency contraceptive can be offered up to five days after sexual violence [15, 17]. Long-term care consists of HIV PEP monitoring, HIV and other STIs repeat testing, pregnancy testing and management, continued psychosocial support, documentation and management of any adverse outcomes of the violence [17, 27].

Research shows that in some parts of the world, more than 50% of people who experience either physical and/or sexual violence do not report or seek help [28, 29]. Those who seek help do so mainly from friends and family. An even smaller proportion, less than 10% in some regions, seeks help from a health facility or medical personnel [20, 29-31]. This trend is common in both violence perpetrated by an intimate partner or non-partner [30-32]. Among those who access healthcare, many do not do so within the recommended time frames and these delays often preclude administration of treatment such as HIV PEP to prevent HIV acquisition and emergency contraceptive to prevent unwanted pregnancy [32]. Studies show that various factors such as distance from the health facility and the geographical region [29, 32]; sociocultural factors such as stigma [32]; the severity of violence and experiencing more than one form of gender-based violence (GBV) [30]; the relationship to violence perpetrator [29]; as well as economic factors [20, 32] affect seeking and accessing healthcare. These studies show that survivors who experience more than one form of GBV, who experience more severe types of violence and who are unrelated to the perpetrator are more likely to seek healthcare. Long distances from health facilities, social stigma and fear, being busy attending to other basic chores such as childcare and business can be a hindrance to seeking healthcare.

Furthermore, long-term follow-up of survivors is sub-optimal in most settings. For instance, in a dedicated sexual assault referral centre in the United Kingdom, only 62% of the women presenting attended any follow-up visits and only 29% had a recommended follow up HIV test after the window period [25]. This trend is repeated across both developed and developing countries including Kenya [3, 4], South Africa [26, 33-36], Brazil [37, 38], United States of America [39] and others. The problem is

even greater in areas of long conflict such as the Democratic Republic of Congo [18, 40]. This poor follow up is of major concern as it implies that many survivors do not benefit from the full course of HIV PEP and treatment for other STIs. Additionally, survivors miss out on trauma counselling, a service that has been shown to reduce the risk of developing mental disorders secondary to the violence [16].

Similar to barriers to care seeking, socio-cultural issues are a core cause of poor retention in care. In a qualitative study interviewing women attending services in South Africa, stigma and perceptions of being blamed for the violence were cited as strong barriers to treatment completion [41]. In addition, distance and inability to afford transport costs, inability to understand treatment requirements, drug adverse effects and poor provider skills and attitudes have been cited as other reasons that make survivors not adhere to treatment or return to care [36, 41-43].

Notably, there is limited evidence of health services for survivors outside the confines of health facilities. Some studies have highlighted the failure of health systems in supporting adherence to treatment through lack of active follow up of survivors who have been started on treatment [41]. Many interventions that have attempted to address the issue of poor access and treatment completion have been focussed on the health facilities; yet, many of the barriers are community based. Hence, a more multipronged response which incorporates community services such as CHWs services may be more successful.

2.2 Community health workers services

Community health workers have become an integral part of healthcare in many low and middle-income countries, and are recognised as an important community resource to bridge the gap between basic community health needs and the formal healthcare system [44]. The WHO defines community health workers as community-based workers who are members of the communities where they work, who are selected by their communities, have received limited training but not trained as professional health workers and are supported by the health system but are not necessarily a part of its organisation [45]. In the simplest form, CHWs visit their communities and

households providing a diverse range of services including health promotion, disease prevention information and simple curative services [44]. However, the actual roles played by the CHWs vary depending on governments, regional disease burden and other stakeholders involved [44].

Evidence from global research indicates that CHWs are a key resource in healthcare particularly in areas where there are limited numbers of healthcare workers, among vulnerable populations and in the hard to reach areas [44, 46]. Benefits of using CHWs include access to marginalised communities, early diagnosis and early initiation of treatment, adherence to medical care, reduced morbidity and mortality as well as retention in care [44, 47-50]. In a review of the global experience of CHWs in relation to achieving the Millennium Development Goals, WHO notes that the services offered by CHWs have led to a decline in maternal and child mortality as well as decreasing the burden of tuberculosis (TB) and malaria [44]. Studies in Pakistan and Brazil using CHWs to screen contacts of TB patients and support continuing treatment reported increased TB case detection and improved treatment outcomes [51, 52]. These two studies were however limited by lack of a control group and, CHWs visits and treatment support were only a component of the whole intervention and therefore difficult to attribute the effects on CHWs alone (other components for instance in Pakistan included provision of transport for suspected TB cases, food baskets and scheduled visit text message reminders to identified cases). Studies in other communicable diseases such as malaria, pneumonia and diarrhoeal diseases have also demonstrated that with training and adequate supervision, CHWs can provide high quality services to patients in the community [53-56]. For instance, a systematic literature review on services provided by CHWs responsible for malaria case management in children found that CHWs were able to provide good quality malaria care including performing diagnostic tests and providing treatment [57].

In HIV, positive impacts of CHWs on adherence to treatment, viral load [46, 58], cluster of differentiation 4 (CD4) counts (an indicator of body immunity status), mental health symptoms associated with HIV [59], retention [58] and mortality [58] have been documented. Similar findings in mental health symptoms and disability improvement

have been documented in India [60]. Maternal and child health have also benefitted from CHWs interventions leading to a decrease in child and maternal mortality with studies showing improvement in uptake of family planning, antenatal clinic attendance, hospital deliveries and breastfeeding [44] [61, 62] [63]. Not only are CHWs interventions important in improving treatment outcomes, but also in identifying patients in the community who may not present for treatment. In countries like Malawi and Tanzania, CHWs interventions have led to marked rise in identification and linkage to care of HIV-infected patients and pregnant women [62, 64].

Evidence from the above health conditions on the roles and impact of CHWs suggest that CHWs have the potential to improve care for sexual violence survivors. Studies show that for most survivors, the first port of call for help is often from within the community either from friends and family or influential community members [28, 29, 41]. CHWs form a part of this pool of community resources. Some governments and non-governmental organisations (NGOs) are incorporating CHWs to carry out different tasks related to care of survivors [40, 65, 66]. However, there has been limited evaluation of CHWs services for sexual violence particularly assessing survivor experiences with these services.

2.3 The Kenyan context

2.3.1 Status of sexual violence in Kenya

Sexual violence is increasingly being highlighted as a growing health and human rights problem in Kenya, however, there is lack of comprehensive data on the actual magnitude of the problem. While national figures collected through the Kenya Demographic and Health Survey (KDHS) show a decrease in prevalence rates (from 21% among women in 2008-2009 to 14% in 2014), local media reports, hospitals and police reports suggest increasing numbers. For instance, in the Nairobi Women's hospitals' Gender Violence Recovery Centre (GVRC) annual reports indicate consistently rising numbers from only 186 cases in 2001-2003 to 2532 in 2011-2012 [67]. The GVRC is a leading provider of sexual violence services in Kenya and while the high figures in this hospital may be attributed to the growing popularity and frequent

media exposure of the hospital as a centre for gender violence services, similar rising numbers reported in other less well known health facilities suggest a generalised increase in cases seeking healthcare [3].

The prevalence rates for sexual violence differ markedly depending on the geographical regions. According to KDHS 2014, the lowest rates are reported in North Eastern with 0.6% of women reporting ever experiencing sexual violence and the highest are reported in Nairobi 20%, Western 21.9% and Nyanza 22%. Variations in the experience of sexual violence are also observed by age, marital status, education and social economic status. Women ages 15-19 years are less likely to report sexual violence compared to older women ages 30-49 years. Single women, women with a secondary education or higher and women from the highest wealth quintile are also less likely to report sexual violence. Among men, sexual violence reporting is highest among formerly married men; among men age 25-40 years compared to older or younger men; and, among men from Nairobi, Western and Nyanza. Incidences are noted to rise markedly during times of conflict such as that witnessed during the post-election violence in 2007-2008 [68].

Among children, a national survey of children 13-17 years on experience of recent sexual violence (in the 12 months prior to the survey) indicates that sexual violence is more common among girls 11% compared to boys 4% [2]. Lifetime experience of sexual violence during childhood is even higher with 32% of females and 18% of males ages 18-24 years reporting experiencing sexual violence before the age of 18.

2.3.2 Meanings of sexual violence in Kenya

In order to understand healthcare seeking behaviour among survivors of sexual violence, delving into people's understanding of what sexual violence is and what impact it has on the survivor is imperative. In addition, it is important to understand that individual views of sexual violence are shaped by the communities in which they are born and where they live. Thus, the decision to seek healthcare and the route that takes is not only dependent on the individual who has experienced sexual violence but

also on the community and culture in which they reside. This section explores the different ways that people understand sexual violence in the Kenyan context and how these may shape the different pathways that sexual violence survivors take to access and sustain care.

Notably, there are broad forms and interpretations of sexual violence both at the community level and by legal definition. For instance, the Sexual Offences Act outlines more than 20 different offences related to sexual violence including rape, attempted rape, defilement, incest, trafficking, child pornography and sexual harassment among others [69]. Due to this wide scope and the fact that survivors experiencing different forms of violence will follow very diverse pathways, this section will focus specifically on rape. It will examine rape from community, legal and healthcare perspectives and will include rape of both children and adults by either intimate partners or any other person.

Community understanding of rape

Diverse views of what constitute sexual violence and cultural interpretations of sex and sexual rights in different communities often perpetuate sexual violence and derail healthcare seeking. Sex and rape are rarely discussed subjects in Kenyan communities [70]. Many communities (Kenya has 42 distinct tribes), do not have a word for rape [71]. Non-partner rape, as opposed to intimate partner rape, is recognised as a violation of an individual. However, it is at times justified by claims that the survivors' brought it upon themselves; ignored as part of a cultural practice; or resolved by compensation paid to the father or husband of the woman raped [72, 73].

Survivors being blamed for rape is common and survivors are said to have brought it upon themselves if they are deemed to have dressed inappropriately; acted seductively; been in the wrong place or wrong profession. In a study done in Western Kenya on rape myths, focus group participants reported that nearly always the survivor is to blame for the rape. The only exceptions were in the rare occasions where the survivor was too young or the rape was committed by the stereotypical rapist who

Tavrow et al describe as “violent, older, used alcohol or drugs, was part of a gang, carried a weapon, was HIV positive, or had demonic or superhuman powers” [73].

There are also cultural practices that condone coercive sexual attitudes towards women. These include wife inheritance where a woman is expected to marry the brother or kin of her deceased husband and ‘widow cleansing’ where a woman is required to have sexual intercourse with a man, to cleanse her after her husband’s death [72]. Culturally, it was also common practice for rape cases to be settled through a compensation paid to the father or husband of the woman raped. This practice stems from old traditions where rape was seen as an offence not on the woman, but a crime against her father or husband [74]. Thus, families and local leaders such as village elders would negotiate with the perpetrator to either compensate the family or in cases of young women, the perpetrator is required to marry the survivor. In addition, because women are considered as part of the property owned by men and therefore as part of their duty to meet the sexual needs of their husbands, rape from intimate partners is tolerated [7, 72, 75].

As mentioned, sex and sex-related subjects are taboo among many communities and therefore adults rarely talk to their children about sex [70, 76]. In many communities, among children, sex is commonly referred to as “bad manners”. By extension, rape is when bad men “catch” girls and do bad manners to them [76]. The ambiguity of this term and the connotation, at least in a child’s mind, that they might somehow have a responsibility in what happened due to their manners, or that it only happens with bad men may hinder children from reporting. A study among young people aged 10-24 years who were sexually experienced revealed that forced sex and rape are regarded as different with those reporting rape more likely to report that it was perpetrated by a stranger [77]. This implies that when an intimate partner such as a boyfriend or husband forces sex, the young people no longer considered it as rape.

In some communities, rape of minors is institutionalised in the form of early customary marriages. In such arrangements, parents and suitors arrange for marriage and the girl has no choice but to go along [72]. Similarly, in some cultures, unsuspecting girls are

abducted into marriages by men who are interested in marrying them but whom the girls do not necessarily want to marry [74, 78]. Although both these practices are illegal and uncommon now, they nevertheless still happen and are culturally tolerated in the communities where they happen. In addition, rape of children by family member is rarely disclosed outside the family [79]. In such instances, healthcare for the survivor is often overlooked.

Legal framework

The Sexual Offences Act, 2006 formally and legally defines various acts of sexual violence in Kenya [69]. It also describes the punishment for those offences under the law. In this Act, rape is defined as penetration with a genital organ, of another person's genital organ, including the anus, without consent or with consent obtained through coercion or force. This offence carries a minimum sentence of 10 years and maximum sentence of life imprisonment. Rape of a child below 18 years, referred to as defilement in this Act, carries a more severe sentence. The sentence is dependent upon the age of the child with defiling a child 11 years or less carrying a mandatory life imprisonment. This law is very crucial in obtaining justice for survivors of rape and other forms of sexual violence as well as acting as a deterrent to would be perpetrators. However, the law has some shortcomings that are fundamental to how rape survivors report and by extension seek healthcare. For instance, this law does not recognise rape among persons who are lawfully married to each other. Consequently, women experiencing marital rape may find it unnecessary to seek healthcare even when they believe they may be in danger of getting infected with STIs/HIV. As the law does not protect them, the feeling that circumstances may not change, unless the woman was willing to leave her spouse, may hinder healthcare seeking.

Healthcare framework

Policy and responsibility for the healthcare management of sexual violence survivors falls under the Department of Reproductive Health in the Ministry of Health (MOH) [8]. The ministry of health draws its definition of rape from the Sexual Offences Act of 2006 and recommends that survivors should seek immediate healthcare. Through the

National Guidelines on Management of Sexual Violence in Kenya, it outline the routine care of survivors who present at health facilities [80]. The care and policy framework has developed over the last 15 years. By the year 2000, healthcare for sexual violence was very limited and there was lack of policy governing this care. However, in the early 2000, in a background of high HIV prevalence, efforts to improve post rape care including introduction of HIV PEP as part of the routine care for sexual violence survivors were stepped up [8].

2.3.3 The healthcare system in Kenya

The right to the 'highest attainable standard of health' for every Kenyan is enshrined in the Kenya Constitution [81]. To achieve its objective of providing healthcare, the government has devolved healthcare services and aims to provide health services closest to the people. In this regard, there are four levels of healthcare [82]. The lowest level of service provision is at the community level and services are provided by the CHWs. At this level the main activities involve demand creation through promotion of health services, disease prevention activities and simple curative services. The second level of care is the primary care level that consists of dispensaries, health centres and maternity/nursing homes. This is the first level with a physical health facility and professional healthcare workers. The third level is the county referral hospitals and the fourth is the national referral hospitals that are highly specialised centres.

In line with the objective of delivering universal healthcare, one of the major areas of focus for the sector is the scale up of community health interventions that have shown high impact while also strengthening the referral systems between the different levels of care [83]. Through the referral system, patients should ideally seek care first from the lower-level facilities that are closest to them, and only be referred to higher-level facilities for services not available at the lower level. However, this referral system often does not work. Consequently, all the facilities including the national referral hospitals ran an outpatient department that attends to walk-in patients including sexual violence survivors. Currently, post rape care services are available in government health facilities throughout the country.

Among the top ten leading causes of death and morbidity in Kenya as outlined in the Kenya Health Policy 2012-2030, HIV/AIDS is number one while violence and injury is number ten [82]. In line with the disease burden, the government has outlined six long-term objectives among them the elimination of communicable diseases, reducing the burden of violence and injury and providing essential care. Most relevant to this study, the government aims to control the burden of HIV/AIDS as the leading cause of death among other communicable diseases. Notably, total control of HIV cannot be achieved without addressing prevention and effective management of sexual violence. A second objective is to reduce the burden of violence and injuries including gender-based violence such as sexual violence. For both these objectives, the community level has been identified as the lowest level of provision of services for responding to HIV and gender-based violence [66, 82, 84].

Community level healthcare is provided by CHWs through the community health strategy. The community health strategy was adopted in 2005 and is clearly defined in the Taking the Kenya Essential Package for Health to the Community: A Strategy for the Delivery of Level One Services and the Kenya Health Policy [82, 84]. The mandate of the CHWs include promoting healthy lifestyles among community members; promoting personal and domestic hygiene; providing treatment for minor ailments; improving community awareness and health-seeking behaviours for existing health and related services; and taking defined interventions and services closer to the community [82, 84]. Thus, CHWs in Kenya are 'generalists' who are tasked with multiple activities to carry out at the household and community level, and reporting requirements to the formal health system. Community health workers work on a voluntary basis with no pay from the government, however, some who work on special programmes sponsored by NGOs receive some compensation based on performance [85]. Lack of financial remuneration for the CHWs has been cited as a cause for high attrition [86, 87].

Each CHW takes care of 20 households, approximately 100 people in total. The CHWs are organised into a community unit of approximately 50 CHWs. Each CHW reports to

a community health extension worker (CHEW) who forms the link between the CHWs and the formal healthcare system. The CHEW is a professional healthcare worker based at the level two or three health facility. There are approximately 2 CHEWs in each community unit and each supervises 20-25 CHWs. The government aims to establish a community unit for every 5,000 persons with a target of 8,000 community units in all. As of 2013, there were 439 community units established in the whole country and the government aimed to increase that number to 5,000 by 2017 [83]. In addition, the government plans to update the community strategy clearly defining the interventions to be implemented at the community units and the roles CHWs should play [83, 84, 86].

According to the CHWs' training handbook, training of CHWs should consist of two sections [66]. The first section consists of six basic module that include community health and development; communication and advocacy; information management and disease surveillance; governance and leadership; health promotion and disease prevention; basic healthcare and lifesaving skills. This training should be provided over a period of 10 days. The second section, to be taken only after completion of the first one, covers technical modules that should be determined based on local needs. Training duration for each technical module varies from 2 to 5 days depending on the content covered [66]. Training on sexual and gender-based violence (SGBV) forms a unit in the health promotion and disease prevention module. In SGBV, the roles stipulated for CHWs are creating awareness of SGBV and available services, mobilising community to respond to SGBV, referring survivors and writing reports.

2.3.4 Pathways to healthcare for rape survivors

Survivors of rape follow different pathways in seeking both medical and non-medical help (figure 2.1). Those who seek help initially do so from their friends, family and local leaders. A population-based survey of young people aged 10-24 years reported that only 23% of women who were raped by either an intimate partner or otherwise talked to anyone else about the incidence [77]. Although this study did not report on the actual number that sought formal healthcare, it observed that the majority of those

who did speak to anyone else about their experience did so to a family member or friend. This is also reflected in the demographic health survey data of 2008-2009 which reported that among women experiencing sexual violence, 53.5% sought help from family, 14.4% from friends and neighbours, 27% from community/ local administration and only 1.1% from a doctor or medical personnel [28]. Similar findings were documented in the 2010 violence against children survey [2]. Among young people who reported having experienced sexual violence when they were under 18 years, 46% of females and 36 % of males told someone else about the abuse, most commonly a relative or a friend. However, less than 4% of them received any services. Similarly, of those aged 13-17 years interviewed, less than 10% of those who reported sexual violence in the 12 months prior to the survey had received any services.

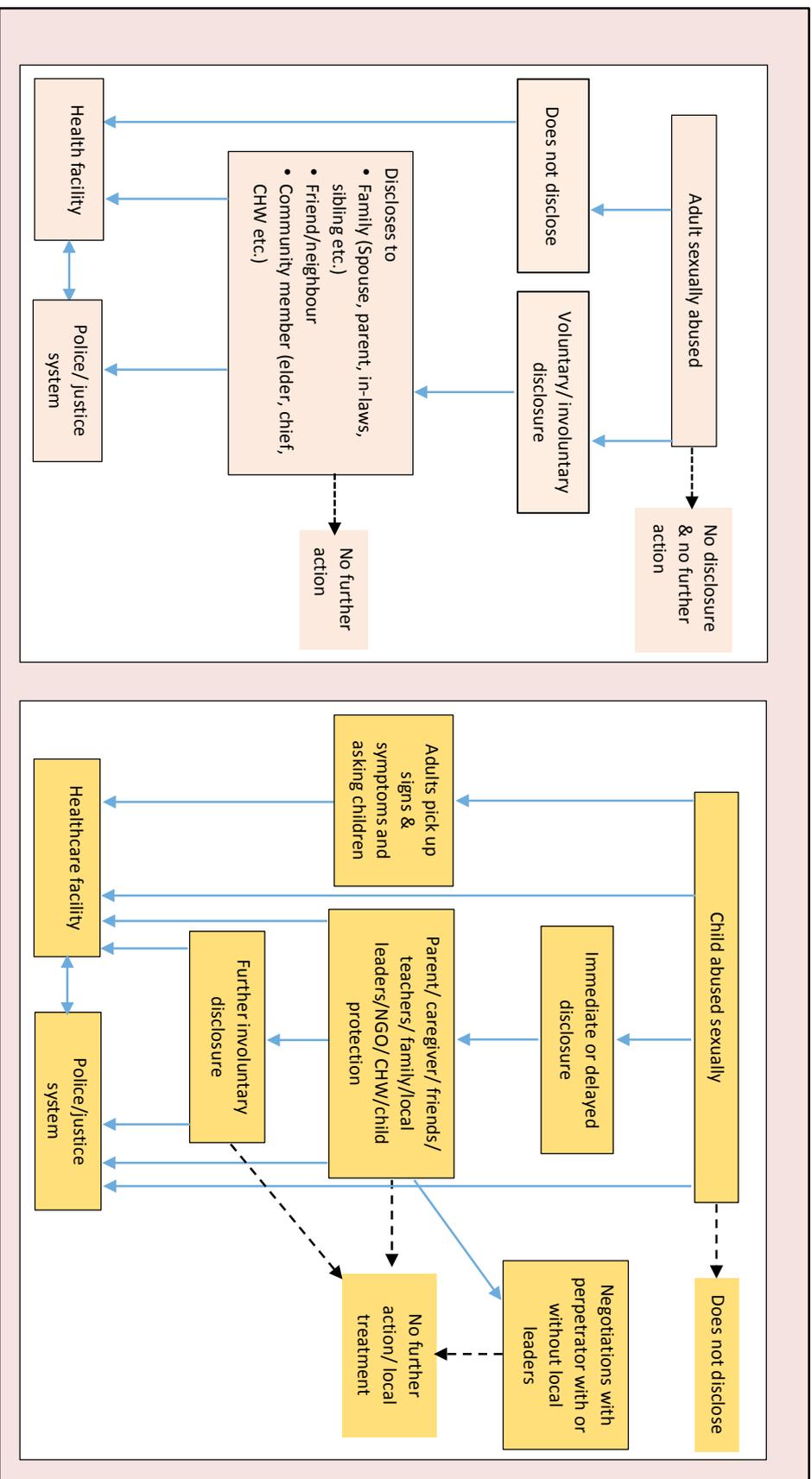
The advice received from the initial person from whom the survivor seeks help plays a crucial role in the next course of action. It can determine whether the survivor reports or seeks healthcare. In qualitative interviews exploring the drivers of intimate partner violence in a rural setting, male and female participants from the community and health service providers observed that when women experienced violence, they most frequently sought help from their in-laws [75]. When they did, they were encouraged to stay silent as violence was an expected part of being a wife and keeping quiet would protect the family's image.

The silence to protect the family is also common where the survivor is a child abused by a relative, making their pathways to care even more complex. Because children do not make decisions on healthcare, caregiver and family interests often override the need for care. Among children, especially those raped by relatives, it is common not to receive healthcare. In an ethnographic study among the Kisii on child protection in the community, many participants observed that although incest was seldom reported in the community channels for child protection, there were children who fell pregnant as a result of rape by relatives [79]. Key informants in this study also pointed out that they knew of cases where children were raped by their relatives but were not reported, with families deciding to settle the matter internally to avoid shame. Similarly, some mothers especially those involved in selling illicit alcohol made their

children have sex with men in order to attract male customers to keep coming to buy alcohol from them. In some instances, the study observed that some perpetrators bribed the parents of the child involved to prevent reporting or provided money to buy local treatment for the girl that was then administered by the mother.

In incidences where healthcare is sought for rape in children, the process may be direct with the child reporting to the mother or immediate caregiver who then takes the child to the health facility. Even, in such an instance, research shows that children often delay reporting instances of abuse to their caregivers due to fear, either of the perpetrator or the consequences from the parents [88, 89]. Another common pathway for children involves reporting to a caregiver who then seeks help from family, CHW or village elder/chief [79]. This may then be followed by going to the health facility. In certain instances, the chief may decide to settle the matter by punishing the perpetrator, paying a fine to the parents or he may refer the case to the police. In other instances, the family will report the matter directly to the police before going to the health facility or the survivor may first go to the health facility and is then referred to the police.

Figure 2.1: Pathways for seeking care for children and adult sexual violence survivors



Abbreviations: CHW- Community Health Worker; NGO- Non-governmental Organisation

Pathways within health facilities

Unclear referral pathways and referral to health facilities that do not provide required services are among the initial obstacles to healthcare among survivors of sexual violence. Ideally, for timely and optimal treatment, a survivor needs to be referred to the nearest health facility that offers comprehensive services. However, research shows that in general there exists a lack of information both at the community and local health facility level on which facilities are equipped to provide comprehensive post rape services [90]. This means that a survivor may be referred to a facility that lacks specific services and this might discourage further seeking of services. Alternatively, a survivor may be referred to a widely known facility that is far from their locality and this may also discourage the survivor from seeking care due to cost and time involved. Furthermore, the survivor may present in this facility but delays in reaching the facility may disqualify them from some of the recommended treatment such as HIV PEP.

The national guideline on the management of sexual violence has a detailed description of the care a survivor should receive on presenting to a health facility [80]. This care includes medical management consisting of a detailed history of the rape and significant past medical conditions; physical examination and attending to any physical injuries; collection of specimens as well as drug administration [80]. Specimens are collected for both medical and forensic purposes and they include blood, urine and genital swabs. Drugs administered include emergency contraceptive, STI prophylaxis including a combination of antiretroviral drugs for HIV prevention that should be started within 72 hours and taken for 28 days. In addition, psychosocial care including trauma counselling is provided. For legal purposes, forensic evidence is collected and preserved and detailed documentation that involves filling in standardised forms is done.

Although the package of care for survivors is standard, the actual step-by-step process of receiving care may differ from one facility to another depending on the type of facility. The health facilities that provide care are distributed among three main levels

of care, from primary healthcare level to national referral level (figure 2.2) and offer either a one-stop centre service or integrated services [82, 91]. In one-stop centres, survivors are provided the whole package of care in one centre, but these are few and found only in some county referral and national facilities. In the integrated services, survivors receive services within the existing health provision structure with all other patients. The primary level facilities consist of health centres and they mainly offer an integrated service. These facilities often lack the full package of care for sexual violence survivors and have to refer survivors to other facilities offering more comprehensive services. The second level comprises of the county referral facilities that offer more comprehensive care and a few have one-stop centres. The national level facilities are two, one has a one-stop centre while the other offers a partially integrated service with survivors being seen in a gender violence centre but referred to other departments for services such as HIV PEP, laboratory, pharmacy etc. In addition, private health facilities as well as local and international NGOs also offer healthcare [90].

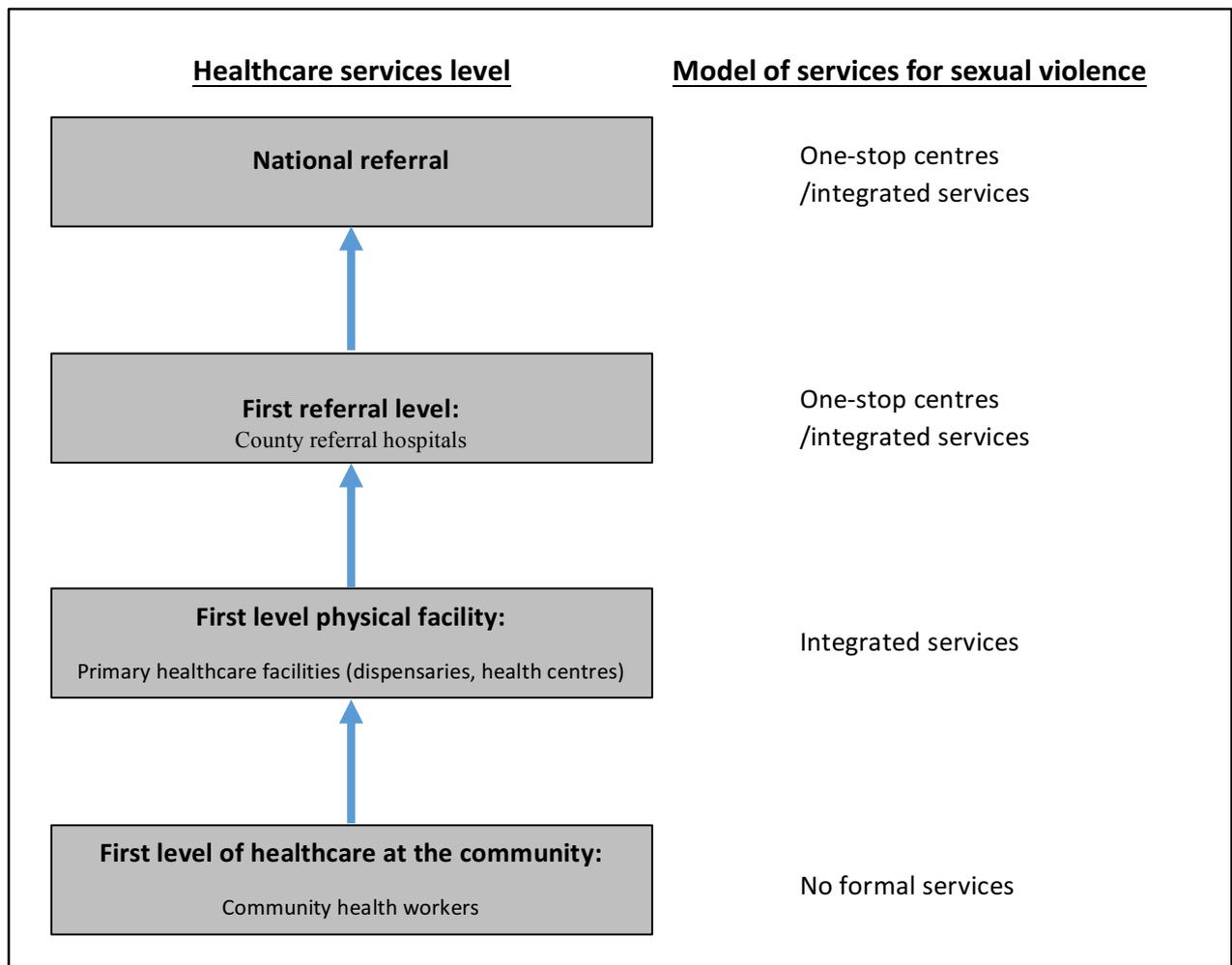


Figure 2.2: Health care structure and model of services available for sexual violence survivors

The majority of survivors are attended in facilities with integrated services and the first point of contact with the health facility is usually the casualty or outpatient department [8]. In most facilities, survivors will queue with other patients and be seen by the same healthcare workers attending to all patients. In other facilities survivors are prioritised and they are seen immediately they present. In a limited number of facilities, a dedicated room is provided for management of survivors and a nurse specifically stationed in this room to attend to survivors promptly [92].

Commonly, a survivor will be ushered in by a nurse who will take a brief history and record the vital signs of the survivor such as blood pressure and pulse. The nurse will then call a doctor to examine the survivor and take specimens. In facilities where a

doctor is not available, a clinical officer (CO) (a trained non-physician medical personnel who is permitted to treat certain conditions) will examine the survivor. This will be followed by the survivor being referred to a trauma counsellor who will provide trauma counselling and pre-test counselling for a HIV test. If the survivor consents, they are then sent for a HIV test. Once the results of the HIV test and other tests are received, the survivor is referred back to the doctor who then prescribes treatment and sends the survivor to the pharmacy to pick up drugs. In some facilities, the pharmacy and counselling are located in the CCC, a different department from casualty [93].

The time between walking into the facility, seeing a doctor and being started on treatment is crucial. It is recommended that a survivor be started on HIV PEP as soon as possible preferably within a few hours of rape and not later than 72 hours since assault [21]. Delays within the hospital can contribute to missing out these important timelines particularly if the survivor had delayed coming to the health facility. Speight et al noted very high drop-out of survivors between casualty and the laboratory for HIV test [5]. They also documented an average of 1.3 hours between the time the survivor walks in and the time they receive their first dose of HIV PEP. Ranney et al also observed that possible shortage of staff and stretched staff attending to all patients in the casualty department hindered delivery of crucial services to survivors such as counselling [92]. In addition, poor referral mechanisms within facilities result in losses to follow-up [8].

HIV PEP completion

Human immunodeficiency virus PEP is undoubtedly one of the most critical interventions for sexual violence survivors particularly in countries with high HIV prevalence like Kenya. Regrettably, failure to start HIV PEP is common. Presenting after 72 hours is one of the commonest reasons for not starting HIV PEP. Studies in Kenya show that between 15-30% of sexual violence survivors present at the hospital after 72 hours [3, 4, 8]. In addition, studies have found that even when survivors do present on time, HIV PEP is at times not started. Ranney et al reported that of 321 survivors

eligible for HIV PEP, only 63% started HIV PEP with no clear reasons why the others did not. Studies on HIV PEP completion have been few and have generally reported low rates. Speight et al reported rates of HIV PEP completion at 52%, attributing this low rate to drug side effects, failure to understand the importance of HIV PEP and rape-related trauma. Another study which comprised a larger and demographically different population reported an even lower HIV PEP completion rate of 35% [4].

Follow-up

The guidelines recommend follow-up for survivors for up to six months after assault [80]. During this time, survivors take HIV PEP at home but attend the health facility on 3-4 scheduled visits. A second visit is recommended between 1-2 weeks after starting treatment during which clinicians assess treatment, assess adherence to treatment and any difficulties the survivor is experiencing. In addition, psychosocial and adherence counselling and refill of drugs if not prescribed in full during the first visit is done. The next visit is usually scheduled 4-6 weeks after the initial visit in which survivors are assessed for HIV PEP completion. Additionally all survivors are recommended to have a repeat HIV test and a pregnancy test in women. Survivors are also provided with psychosocial counselling and any vaccines started earlier such as hepatitis B and tetanus toxoid are continued. The next two visits are scheduled at three and six months and thereafter as and when necessary.

Speight et al noted a high loss to follow up following initiation of treatment common in both children and adults although children were more unlikely to attend the 6 weeks follow-up HIV testing visit [5]. High loss to follow up was also reported by Siika et al where 52% of survivors failed to return after 4 weeks and did not attend repeat HIV testing as recommended [4]. Loss to follow has been attributed to various factors including the need to attend multiple service delivery points at the hospital, fear due to stigma of collecting antiretroviral drugs, hospital charges, drug adverse effects and lack of active follow-up once survivors have been started on treatment [4, 5].

2.3.5 Roles of community health workers in the continuum of care for sexual violence survivors

As early as 2006, researchers were recommending that more closer community-based follow-up such as that provided by CHWs would improve support for survivors as well as ensure better reporting of data on adherence and HIV PEP completion [5]. Community health workers can provide the active follow-up that has been reported to be currently missing and contributing to poor retention. As mentioned earlier, members of the community such as family, neighbours and local administration are usually the first contacts that survivors seek help from. Community health workers are part of this community resource and can form a knowledgeable first source of information and support that can ensure survivors are linked to appropriate care.

Even with the policy and training recommendations provided, there are no official data on the actual implementation of CHWs services for sexual violence or their impact. Anecdotal evidence however shows that CHWs are nevertheless involved in different ways. For instance, CHWs routinely come into contact with sexual violence survivors during their work in the community. In a recent unpublished study by a local NGO, healthcare workers in some government health facilities reported that they often utilise CHWs to trace lost sexual violence survivors. The same NGO, plans to conduct research on utilising CHWs in monitoring adherence to HIV PEP, providing retention and referral services [94]. In addition, an on-going study is using CHWs to provide post-rape counselling and psychosocial support at the community level [95]. Despite this involvement of CHWs and the potential roles that CHWs can play in this care, there is not enough evidence to inform 'best practice' in incorporating use of CHWs in sexual violence care. There is paucity of data on roles CHWs can effectively play in sexual violence services and how feasible and acceptable their roles are to the sexual violence survivors.

2.4 Research gaps

Poor access to care, poor treatment completion and high loss to follow up of sexual violence survivors is a global problem yet no exemplary models to address this issue

exist. There is limited data and particularly qualitative research with survivors, on reasons for not seeking care, the high loss to follow up and their preferred mode of service delivery [41, 43].

In Kenya, different stakeholders are adapting the CHWs model to sexual violence survivors follow up but questions abound on its effectiveness and feasibility particularly in an environment where sexual violence is often a silent and private issue. There is limited data focusing on the actual experiences of CHWs and sexual violence survivors particularly related to stigma and any measures put in place to address it in CHWs programmes. Preliminary search of literature identified no studies that have measured the adverse effects or benefits of using CHWs on sexual violence.

There is also lack of data on the impact of delivering health services to sexual violence survivors on the CHWs themselves, which could include fear for personal safety, vicarious traumatisation etc., or the support the CHWs require from the health services. Similarly, there were no studies identified on potential recipients of CHWs services who decline to utilise these services. These would be important to define characteristics of those who decline, the factors that influence their decisions and any relation if any these decisions have to do with sexual violence stigma.

In summary therefore, there is limited data to inform targeting of interventions to improve access and treatment completion in survivors of sexual violence as well as the development or identification of “best practice models” of alternative outreach services such as CHWs services.

2.5 Study conceptual framework

The phenomena of healthcare-seeking and utilisation of available health services is the subject of multiple theories and models that attempt to explain what factors determine whether an individual will access and use available health services or not. According to the theory of planned behavior, an individual's likelihood of taking up a behavior or using a service is influenced by their attitude towards that behavior whether positive or negative resulting in their intention to perform that behavior or take up a service. Additionally, subjective norms related to other people's opinions of the behavior/service and the perceived individual control over the behavior affects their behavior intention and may result in taking up a service or not [96, 97]. According to the health utilisation model [98], an individuals' use of healthcare is influenced by individual factors such as age and gender, the prevailing health system factors such as resources available and their distribution as well as societal factors such as social norms.

Similarly, the stigma theory recognises that aspects of stigma such as labeling, stereotyping, discrimination, status loss etc. can affect the health of an individual and their utilisation of health services [99]. Stigma exerts its influence on healthcare utilisation at the recipient, the healthcare worker and the society level. Stigma levels in a community regarding a particular health condition determine how people with that condition are treated and how services for the condition are viewed within the community. This in turn affects how an individual with the condition responds, and if a condition is socially acceptable in the community it is more likely that the individual will be comfortable seeking and receiving services for this condition even if the services are being delivered by a member of their own community. In contrast, individuals who are stigmatised often engage in strategies to hide their condition and appear to be like everyone else in order to maintain their status in the community [100]. Factors that influence help-seeking and health services utilisation among survivors of gender-based violence such as sexual violence [31, 101, 102] mirror the general phenomena of health seeking and utilisation discussed above.

Data on CHWs services for sexual violence is limited and this study used the conceptual model outlined below (figure 2.3) to investigate the interactions between various service seeking and utilisation factors (as identified above) and CHWs services for sexual violence. Potentially, CHWs can play various roles in the sexual violence care pathway that starts from when a survivor is assaulted with the need to access quality health services in time and the ability to continue receiving these services for as long as they are needed. This would result in desired outcomes such as prevention of HIV/STI acquisition, prevention of pregnancy, reduced mental health symptoms, satisfaction with services provided etc. However, literature shows that this pathway often results in high attrition at various points as individual, society and health systems factors can limit the progression. These factors also act on each other providing either synergy or barriers to reaching these outcomes (as indicated by the broken arrows). For instance, individual survivor feelings of shame, fear and guilt can be amplified in a society whose norms tend to blame the survivor for the violence. Conversely, a society that rejects abuse can be supportive of the survivor seeking help. Community health workers have the potential to improve services for the survivor. However, their individual characteristics, their ability to foster confidence and trust in the community can determine how successful or not their activities are. Similarly, a health system that does not support CHWs in terms of providing guidance, supervision, resources etc. can hamper the CHWs ability to deliver effective services.

In line with this framework, I explored the link between survivor healthcare needs, potential CHWs services, the factors that may influence use of these services and desired outcomes. Through a systematic review I identified different models of CHWs' services for sexual violence, characteristics of both the CHWs and sexual violence survivors and the impact of the services. The quantitative and qualitative data addressed the link between survivors' healthcare needs and factors affecting the utilisation of services. Quantitative data identified characteristics of survivors seeking healthcare, the services they received and pointed out groups of survivors missing treatment nationally. Interviews with survivors collected data on the survivors' views on what services they need, how these services should be provided, their experiences receiving services and their views on CHWs services. Interviews with healthcare

workers identified challenges within the health system limiting the quality of services provided. Finally, interviews with CHWs and other stakeholders collected data on potential CHWs services for sexual violence, and the benefits and drawbacks to such services.

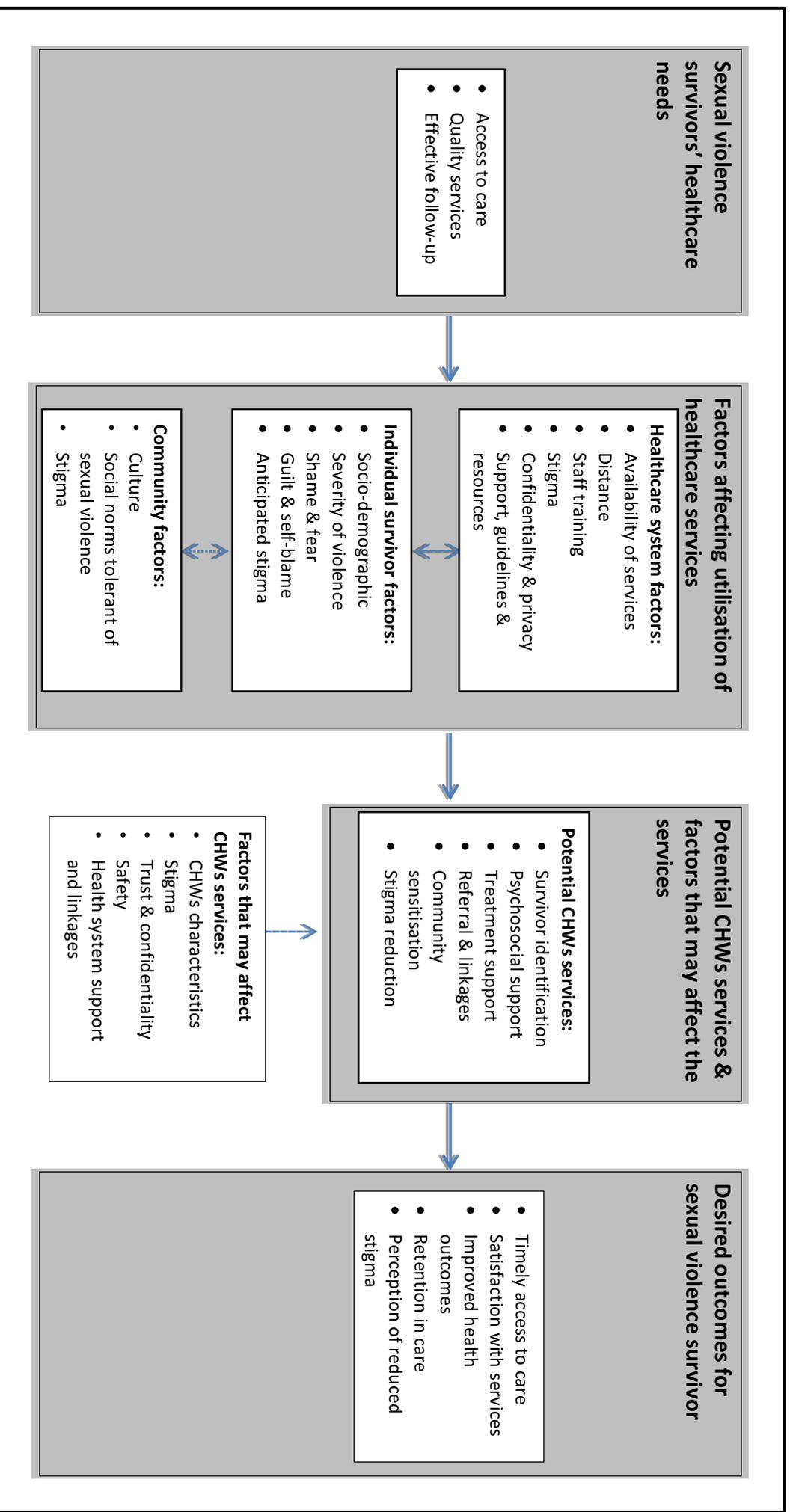


Figure 2.3: Survivors' health service needs, desired outcomes of services and determinants of utilisation

Chapter 3: Methodology

3.1 Introduction

This chapter presents the methodology used for this study. It starts by outlining the overall study design and the study location. It then describes the methods for each of the three components of the study, namely the systematic review, the quantitative data review and the qualitative data collection and handling. Finally, the ethical considerations are outlined.

3.2 Study design

A mixed-methods approach was used, collecting and analysing both quantitative and qualitative data. The premise of mixed methods design is that using this approach provides the most substantive answers to research problems compared to either approach alone [103]. Thus, the quantitative and qualitative methods for this study were chosen to complement each other in addressing the objectives of the study. For each objective, specific methods best suited to answer the research questions were chosen as follows:

Objective 1: To understand the benefits and challenges of using CHWs to provide support services for sexual violence survivors in diverse settings

A systematic review was used as it provides the best way to synthesise available evidence. Such a synthesis allows gathering of best available evidence which is important for healthcare decisions [104]. Thus, I was able to review all the evidence available on CHWs services for sexual violence in different settings and this informed the next phase of my research particularly the development of tools.

Objective 2: To describe the characteristics of sexual violence survivors and the healthcare services provided in Kenya

Quantitative methods were used to characterise the survivors presenting within the facilities and to further compare and contrast these with national level data on characteristics of survivors. Qualitative methods were used to provide deeper insight to the quantitative findings helping to augment the findings and provide explanation to some of the quantitative findings.

Objective 3: To explore the experiences of sexual violence survivors in seeking and receiving care, and the role of CHWs in the care pathways

Qualitative methods using structured in-depth interviews were chosen to allow exploration of the 'lived' experiences of survivors while seeking care.

Objective 4: To explore CHWs and other stakeholders' views and experiences on delivering support health services to sexual violence survivors in Kenya and the acceptability and feasibility of CHWs' services

As with objective 3, in-depth interviews were used to delve deeper into CHWs and other stakeholders' views regarding healthcare for sexual violence survivors as well as the acceptability and feasibility of CHWs' services.

The components of a mixed methods study can be undertaken at the same time or sequentially with either the quantitative study undertaken first followed by the qualitative study or vice versa [103]. This study had an aspect of both concurrent and sequential design. In the first instance, a systematic literature review involved analysis of both quantitative and qualitative studies of existing services by CHWs for sexual violence. The findings of this review and additional literature review helped inform the development of interview guides for the primary qualitative study. This was followed by analysis of quantitative health facility data on survivors who had been attended to in the two facilities. The aim of this analysis was to describe characteristics of survivors who present for healthcare at these facilities and the services offered to them. In addition, comparison with national survey data enabled me to identify groups of survivors missing treatment. Qualitative data through interviewing sexual violence survivors, CHWs, professional healthcare providers and other stakeholders were then collected. Qualitative in-depth interviews provided additional insight to some of the quantitative findings; identified challenges experienced by healthcare workers in offering services to survivors; explored survivor experiences with healthcare services and examined the perceptions of different groups of participants on CHWs services for sexual violence.

Quantitative and qualitative data were analysed first individually. The systematic review data were analysed separately for quantitative and qualitative studies and

findings incorporated through a segregated mixed-methods synthesis framework [105]. The primary qualitative data were analysed through thematic analysis [106]. The findings from each source were then triangulated at the interpretation stage in order to draw conclusions and recommendations [107]. Figure 3.1 summarises the process of data collection and data handling from the different sources.

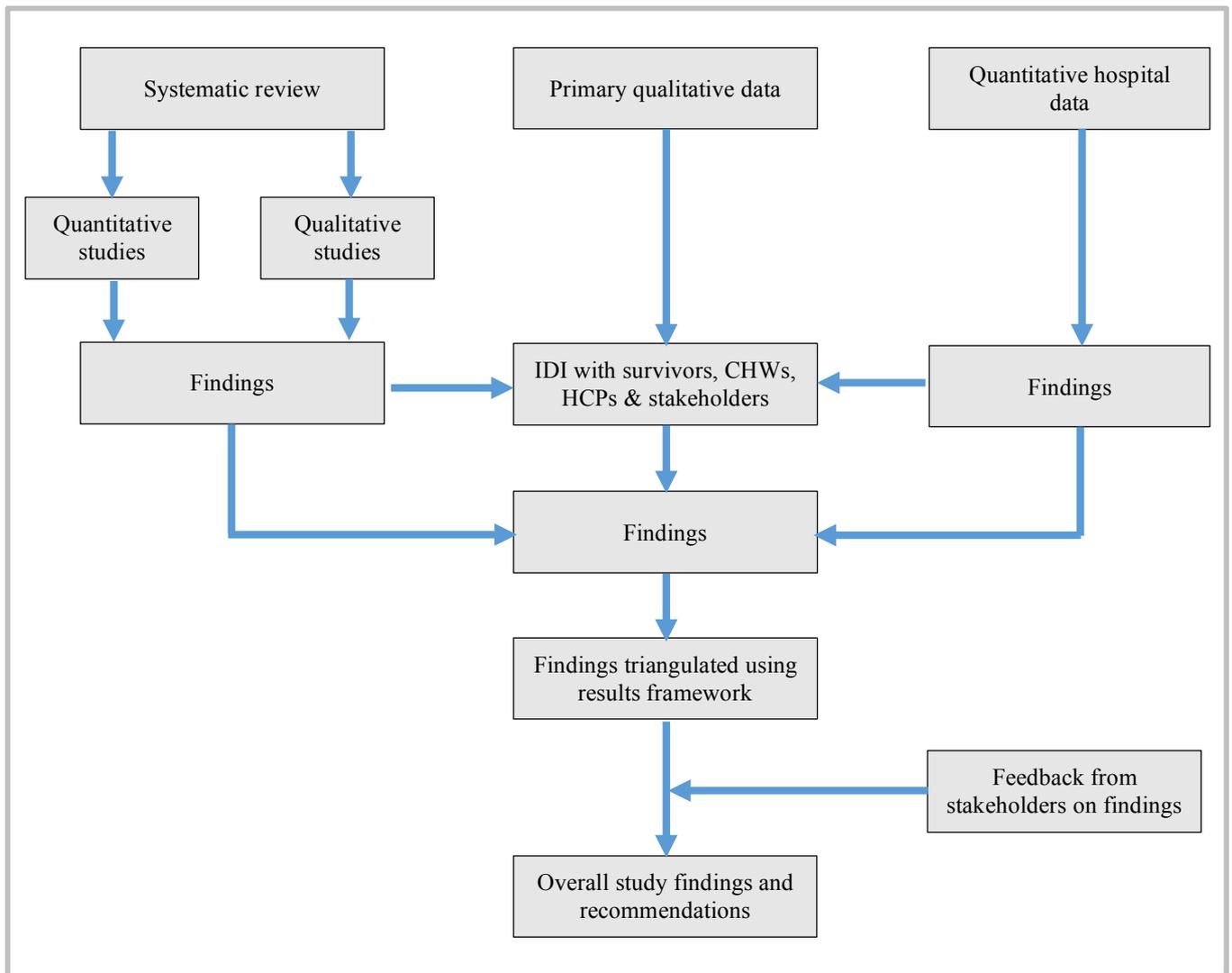


Figure 3.1: Data handling from the systematic review and case study

3.3 Study location

Two health facilities, Naivasha Sub-county Hospital and Thika Level 5 Hospital as well as a local NGO, Wangu Kanja Foundation (WKF), were purposively chosen for the study. The two facilities were purposely selected as they both have relatively high numbers of sexual violence survivors and functional CHWs units. In addition, interventions with CHWs in various roles in sexual violence healthcare are taking place in these hospitals or proposed to take place. For instance, Naivasha Sub-county Hospital is one of the proposed sites for an intervention by a local NGO, Liverpool Voluntary Counselling and Testing Care and Treatment (LVCT) Health. This intervention would involve using CHWs to trace survivors who do not complete treatment, monitor HIV PEP adherence, provide appointment reminders and referral linkages. Similarly, Thika Level 5 Hospital has been a site supported by LVCT for multiple interventions to improve post rape care services since 2003 [5]. Therefore, they provided suitable locations for the study of CHWs services for sexual violence. I had previously conducted research in the two facilities and was familiar with the service provision processes. I considered this a practical advantage given the limited time available for my research as my knowledge and previous association meant that I would need less time to establish a working relationship with the staff. The WKF organises support groups for violence survivors and was chosen for purposes of recruiting survivors who had not sought healthcare.

Naivasha Sub-county Hospital is situated within the Nakuru County approximately 90km northwest of the capital city, Nairobi. It is the fourth most populous county (out of 47 counties in the country) with over 1.6 million people residing in it [108]. The population is multi-ethnic comprising of people from all over the country. In terms of healthcare, Naivasha Sub-county Hospital is one of only three level four referral hospitals out of 278 health facilities within Nakuru County. Previous data indicated that Naivasha Sub-county Hospital had been offering post-rape care services since 2005 and in the year prior to this study, 2014, 356 survivors were attended to at this facility.

Thika Level 5 Hospital is located within the Kiambu County, which borders the capital Nairobi to the east. The county has a population of approximately two million people [108]. The population is diverse comprising of people indigent to the area as well as migrants from all over the country, many of whom work in the capital city. The county has 364 health facilities and Thika Level 5 Hospital is the only level five referral facility. Thika Level 5 Hospital has been offering comprehensive post-rape care services since 2003 and had approximately 235 survivors treated in 2014.

Both health facilities routinely collect data on survivors. The data are collected using three MOH approved forms for sexual and gender-based violence, the MOH 364 (SGBV monthly summary), MOH 365 (SGBV register) and MOH 363 (post-rape care (PRC) form). The MOH 364 is a monthly summary of all survivors seen in a facility and documents the total number of survivors seen, the number presenting within 72 hours, the number initiated on various treatment including HIV PEP, the number tested for HIV and those who tested HIV positive. This data is categorised for males and females as well as for different age groups. The MOH 365 contains data entries from all survivors and includes socio-demographic characteristics, details and nature of the sexual violence, perpetrator and treatment details. It also documents the four follow-up visits that a survivor is scheduled to attend over a period of 12 weeks.

The MOH 363 form is filled in for each survivor. This form summarises the details of the individual survivor and is particularly useful for legal purposes as it is used to fill in the police medical examination report form (P3) (a general police record form for all types of violence). The form is filled in triplicate and the original goes to the police and is used for evidence in court, a copy of the document is given to the survivor while another copy remains at the facility. The form documents a wide range of data that includes the socio-demographic characteristics of the survivor, the nature of the sexual violence, where it occurred and when, who the perpetrator was, the physical examination findings on presentation, investigations done, results of the investigations, treatment given and referral. Quantitative survivor data were primarily extracted from this form.

3.4 Systematic review

I conducted a mixed methods systematic review that involved synthesis of data from both qualitative and quantitative studies. The importance of including both qualitative and quantitative evidence in systematic reviews is recognised and recommended. Researchers observe that for policymakers and managers to make informed decisions on policy and organisational change, they need access to evidence from multiple sources and mixed methods systematic reviews can provide this type of evidence [109, 110]. The process and strategies for conducting mixed methods systematic reviews are diverse [109, 110]. Sandelowski writes of three main research designs for conducting mixed systematic reviews [105]. These are: separately synthesising qualitative and quantitative data followed by a combined analysis of the findings; an integrated framework where both qualitative and quantitative data are synthesised together; and a contingent framework where synthesis is done sequentially with the subsequent synthesis topic/question generated from the previous one. In line with my study objectives, the review was a comprehensive synthesis of qualitative and quantitative data separately which were then combined into a final synthesis. Findings from the qualitative and quantitative synthesis were interrogated for similarities, differences or complementarity. The detailed systematic review methods are presented in Chapter 4.

3.5 Quantitative data

3.5.1 Study population and data abstraction

I aimed to extract all available data covering at least 12 months prior to the study period. In Naivasha Sub-county Hospital, the records available covered 18 months starting from March 2014 to September 2015 while in Thika Level 5 Hospital, records available covered 17 months starting from June 2014 to October 2015 when data abstraction took place. All survivors, presenting within these time periods with any form of sexual violence were eligible for inclusion.

Data were primarily abstracted from the PRC form (appendix 1). Data were abstracted directly from the PRC forms into an excel spreadsheet. I developed the excel

spreadsheet to closely resemble the PRC form as much as possible in terms/wording used and sequence of information. This was important to ensure the extraction was as accurate as possible. To avoid going back and forth looking for data in the PRC forms, the variables extracted followed the same order as the entries in the PRC form. Data entry research assistants extracted the data. To qualify, an assistant needed to have experience in data entry and have some medical background or previous experience of collecting and entering medical data.

At the beginning of the exercise, I went through the data extraction and entry procedures with each assistant. We reviewed the PRC form in relation to the variables to be extracted. I then observed as the assistant did the initial entries. Once data were extracted, I double-checked all the entries against each PRC form correcting any errors and filling in any missing data. Where missing values or outliers could not be resolved from the PRC form only, I made further efforts to find the data from other sources. For instance, the nurse counsellors kept a daily record of the clients they saw and a summary of the discussions and procedures with each client. This daily record was very useful in filling in missing dates and procedures done. Other missing data were extrapolated judiciously. For example, if gender was missing but there was a record of a pregnancy test or contraceptive being issued to prevent pregnancy, female gender was assigned. Where data were totally missing and could not be deduced, an entry was made as 'not documented' rather than missing. This was important to distinguish between data that were missing because the research assistant did not fill it in and data that were missing because it was never collected.

National data were obtained from the Kenya demographic and health survey 2014 and the Violence Against Children Survey (VACS) [1] [2] and are described in detail in chapter 5.

3.5.2 Data analysis

Data were cleaned and imported into Stata (Stata Statistical Software: Release 14. College Station, TX: StataCorp LP). Descriptive summaries for survivor socio-demographic characteristics, nature of sexual violence acts and treatment services

were computed. Proportions were calculated for categorical variables and means were calculated for continuous variables. Comparisons across the two hospitals were done using chi-square test for various categorical variables and t-test for means. To compare hospital and national survey data the following datasets were appended: the male and female datasets from the KDHS 2014, the male and female datasets from the VACS 2010, and the hospital dataset. Differences in characteristics of the survivors were assessed using chi-square tests. Further details of the analysis are described in chapter 5.

3.6 Qualitative data

3.6.1 Introduction

The overarching purpose of this component of the study was to get an in-depth understanding of the actual pathways that survivors use to access care- both formal and informal- and any intersections with CHWs services along these pathways. I aimed to explore the experiences of survivors right from when the violence occurred, when they sought help of any kind, their experiences at the hospital, experiences during follow up and any interactions they may have had with CHWs. In particular, I wanted to understand the barriers they encountered along the care pathways that impacted on their ability to access healthcare and to complete treatment. Given the aims of my study and the need to understand the ‘lived’ experiences of the survivors, the reasons why they may or may not use CHWs services, a qualitative approach was the most appropriate. Moreover, I wanted to explore the acceptability and feasibility of CHWs in sexual violence services. Therefore, in addition to eliciting survivors’ views, I also collected data to explore the perceptions of professional healthcare providers, CHWs and other stakeholders in sexual violence care regarding CHWs services.

I conducted in-depth interviews with sexual violence survivors, CHWs, healthcare providers and stakeholders involved in provision of sexual violence services. Sexual violence survivors and CHWs were selected purposively from the two health facilities and the WKF. Professional healthcare providers were also purposively selected from the two health facilities while stakeholders were selected from a local NGO, an

international NGO and the government. In addition to in-depth interviews, informal meetings with other stakeholders not formally interviewed were held.

3.6.2 Study instruments and interview process

I used a standardised open-ended interview approach [111]. This meant that I prepared a set of open-ended questions for each group of interviewees (appendix 2-6). The interview guides were developed based on the study objectives and themes identified during the literature review. While these guides were not an “exact prescription” of the questions that I discussed, they provided a roadmap for the discussion [112]. I asked the questions and depending on the answers given, I probed further. Having this guide helped ensure that I covered all the relevant themes while the flexibility to probe further allowed me to explore any emerging ones. I developed the initial guides. My supervisor then reviewed the guides and provided suggestions on how to improve the questions and other additional questions. I then conducted ‘mock’ interviews using the guides to assess the language, content and interviewing skills. My supervisor and a member of my advisory committee then listened to the interviews and provided feedback. The feedback provided was helpful in several ways. Firstly, it helped refine the content, language and flow of the questions further. Secondly, it gave me tips on how to improve my interviewing skills. For instance, my supervisor pointed out instances where I could have probed more and also, my propensity to ask double-barrelled questions. Once the fieldwork started, I again sent the initial interview transcripts to my supervisor who again provided feedback on the actual interviews. She also observed one interview with a stakeholder and commented on the content of the interview, my demeanour during the interview and other areas of improvement. I used all this feedback to refine the questions and my interviewing skills for the subsequent interviews.

All the interviews were conducted in a private room. Informed written consent was obtained from all the participants. All the participants agreed to have the interview audio-recorded. I also took limited handwritten notes particularly as a way of keeping track of areas I needed to explore further during the interview or interesting

observations such as body language. Each interview lasted between 20-90 minutes. Interviews were conducted in English and where a participant was not comfortable with English, Swahili, the Kenyan national language, was used. I am fluent in both English and Swahili. However, there was one interviewee who spoke Swahili but having realised that I spoke her mother tongue (Kikuyu), mixed both languages during the interview.

Throughout the research period, I kept a research diary where I documented experiences, observations, points of clarification etc. I also documented any new ideas and insights coming out of interviews held that required additional exploration in subsequent interviews.

3.6.3 Data management and analysis

Qualitative data were transcribed verbatim and typed out in Microsoft Word. Two research assistants and I did the transcription. The research assistants were purposely chosen because of their experience collecting and transcribing SGBV data. Both work as project officers for a local NGO that carries out research in SGBV to inform government policy on SGBV programming. A project officer is in-charge of a specific project with various responsibilities that include writing proposals, supervising implementation of the project, conducting research interviews, transcribing and analysing data. As such, they not only had vast experience in transcribing data, but were also quite familiar with the high level of confidentiality required for SGBV data.

Interviews in Swahili were first transcribed in Swahili and then translated into English. Because I conducted all the interviews I was quite familiar with the content. Nevertheless, I did multiple readings of all the transcripts to ensure consistency and accuracy of transcripts when compared with the audio recordings. The assistants were requested to time-stamp the transcripts to indicate when the interviewer and participant start speaking. This enabled me to reference the audio recordings when reading the transcripts. This made it easy for me to go back to the audio and clarify anything that did not seem clear in the transcript. For instance, because the interviews

were transcribed verbatim, some Swahili words and phrases change meaning once translated into English. In addition, some Swahili words have more than one meaning depending on the context in which they are used. For example, the word “mama” could mean mother, woman or wife depending on how it is used. Having done all the interviews, I was able to identify where the transcriber or translator may have changed the meaning of a phrase or word and go back to the audio to confirm and correct this. Once I had read the transcripts, I imported them into NVivo 11 software that I used for coding.

Data were analysed thematically [106]. Both deductive and inductive approaches were used. Key themes and codes were first developed based on study objectives, literature and conceptual framework. To begin with, I printed out two interviews and manually coded these using the predetermined codes (deductive). While coding, I noted down any emerging new ideas and concepts from the data not categorised previously. I then gave them new themes and codes (inductive). Once I was through with the two interviews, I updated the coding framework. I then used Nvivo to code the interviews into these themes and sub-categories and new ones emerging were added accordingly. To improve reliability of coding and ensure that I was not over-interpreting (or under-interpreting) information, my supervisor reviewed two coded transcripts. She first read through the transcripts and codes and added her thoughts (double-coded) as she went through before looking at my coding framework (to avoid being overly guided by my framework). She then read my coding framework afterwards and thought about other things that she would add to the coding framework. In addition, one of the advisory committee members also reviewed the coding on one other transcript, suggested additional themes and codes as appropriate. With this input, I updated the coding framework.

Once data were coded, I then sorted it and grouped materials with similar codes together. I then synthesised the data through critical reading and summarised the contents through matrix charts consisting of each major theme, sub-categories and relevant data from each participant [106]. From these charts, I then made interpretations and summarised findings.

Note: Methodology specific to particular groups of participants is described in the chapters presenting qualitative data (Chapter 6 & 7)

3.6.4 Reflexivity

During this entire process of collecting data and analysing it, I was cognisant of the fact that my identity and experience may affect how I collect, view and interpret the data [113]. For instance, being a medical doctor, I had predetermined ideas of what health services for sexual violence survivors should constitute as well as what services CHWs are capable of delivering. In addition, although I had done qualitative research before [114], my background was more quantitative than qualitative. My training could also be viewed as a 'hindrance' to being a good qualitative researcher. As a medical doctor, I was trained to be the 'expert' and to provide solutions to problems, often at short notice. As a qualitative researcher, I needed to go in as a learner, patiently wait for the interviewee to express his/her point (overcoming the temptation to summarise) and to acknowledge my interviewee as the expert in my subject of enquiry. This meant a lot of learning was required of me to overcome my perceived shortcomings.

I used several methods to do this. To begin with, I read a lot of literature on qualitative methods. From this literature, I gained a deeper understanding of qualitative research and the methods used. I also attended courses at London School of Hygiene and Tropical Medicine (LSHTM) on qualitative research, analysis and use of Nvivo software. Secondly, I talked to several other PhD students who had done qualitative research who shared ideas on appropriate methodology and their own experiences conducting qualitative research. In addition, my advisory committee comprised of members with extensive qualitative experience and I received invaluable input from these members at different stages of the study. As mentioned already, my supervisor who is an experienced qualitative researcher, walked with me throughout the process providing references, revising tools, reading transcripts and coding framework as well as listening to interviews. Her feedback as well as the feedback from the advisory committee members helped improve my qualitative skills tremendously.

It is notable however that my background was not a total drawback during the process as it also provided some advantages. Knowing the healthcare system well meant that I knew the gaps that existed and was therefore in a better position to explore these with my interviewees. In addition, having interviewed and treated sexual violence survivors before, I was able to connect with them, empathise with them while at the same time maintaining a professional objectivity to their situation. Being able to connect with them ensured that the survivors were able to open up to me and had a more in-depth conversation. My background also meant that I was able to recognise any signs of distress, offer immediate help where needed and refer survivors for further help.

3.7 Ethical considerations

Ethical approval for this research was obtained prior to commencement of study from the institutional ethics review committees of the London School of Hygiene and Tropical Medicine and Kenyatta University. Permission to conduct the study was obtained from the relevant county authorities and the officer in-charge of each facility (Appendix 7: 1-5).

All participants gave written informed consent prior to being interviewed. A study information sheet and informed consent form were first read to them before they consented (Appendix 8: 1-3). All participants were informed that they could decline to answer any questions they were uncomfortable with or stop the interview at any time.

Confidentiality of all participants was maintained throughout the study. Consenting and interviews were done in a private room. This was at the Youth Friendly Centre for all the survivors, CHWs and professional healthcare providers in Naivasha Sub-county Hospital. In Thika Level 5 Hospital, survivors and professional healthcare providers were interviewed in a room at the HIV CCC while CHWs were interviewed in a room at a local primary school. Survivors from the WKF were interviewed at their usual meeting place, which was a room in a local café. I met the costs associated with travel to the venue of interview for all interviewees as well as the venue charges and refreshments for the interviews held in the café.

Participant anonymity was maintained by ensuring that in place of personal identifiers such as names, a code was used on the study instruments. Interview notes, transcripts and audio-records were stored in a locked cabinet and only I had access to study records and any identifying information. Data in study laptop as well as NVivo data were encrypted and password protected. Any individuals' names mentioned during the interviews were anonymised during transcription. These data will be archived in a secure server at LSHTM in anonymised form for 10 years after the completion of the study, in accordance with the LSHTM data storage policy.

Chapter 4: Research Paper 1. Should community health workers offer support healthcare services to survivors of sexual violence? A systematic review

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SECTION A – Student Details

Student	Anne Gatuguta
Principal Supervisor	Prof Gill Walt
Thesis Title	Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors: A systematic review and case study in Kenya

If the Research Paper has previously been published please complete Section B, if not please move to Section C

SECTION B – Paper already published

Where was the work published?	
When was the work published?	
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion	
Have you retained the copyright for the work?*	Choose an item. Was the work subject to academic peer review? Choose an item.

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SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	BMC Health Services Research
Please list the paper's authors in the intended authorship order:	Anne Gatuguta, Barbra Katusiime, Janet Seeley, Manuela Colombini, Isaac Mwanzo, Karen Devries1
Stage of publication	Choose an item. SUBMITTED

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	I designed the review, developed the inclusion criteria, screened titles and abstracts, appraised the quality of included papers, and drafted the manuscript
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Student Signature: [REDACTED]

Date: 06/04/2017

Chapter 4: Should CHWs offer support healthcare services to survivors

Supervisor Signature: _____



Date: _____

6. 4. 2017

4.1 Abstract

Background

Sexual violence is widespread, yet relatively few survivors seek healthcare or complete treatment. In low and middle income countries, community health workers (CHWs) have the potential to provide support services to large numbers of survivors. The aim of this review was to document the role of CHWs in sexual violence services. We aimed to: 1) describe existing models of CHWs services including characteristics of CHWs, services delivered and populations served; 2) explore acceptability of CHWs services to survivors and feasibility of delivering such services; and 3) document the benefits and challenges of CHW-provided sexual violence services.

Methods

Quantitative and qualitative studies reporting on CHWs and other community-level paraprofessional volunteer services for sexual violence in prevention, treatment and follow-up were eligible for inclusion. Quality of included studies was assessed using two quality assessment tools for quantitative studies and the methodology checklist for qualitative studies by the National Institute for Health and Clinical Excellence. Data were extracted and analysed separately for quantitative and qualitative studies and results integrated using a framework approach.

Results

Seven studies conducted in six countries (Democratic Republic of Congo, Rwanda, Burma, United States of America, Scotland, Israel) met the inclusion criteria. Different models of care had diverse CHWs roles including survivor education, awareness creation, identifying and building relationships with survivors, psychosocial support and follow up. Studies often did not report on CHWs characteristics and how they were selected. Few studies assessed acceptability of CHWs services to survivors or feasibility of delivery of different models. However, participants mentioned a range of benefits including decreased incidence of violence, CHWs being trusted and approachable members of the community, non-judgmental and compassionate. Challenges identified relate to high workload, confidentiality issues and community norms influencing CHWs performance.

Chapter 4: Should CHWs offer support healthcare services to survivors

Conclusions

There is a dearth of research on CHWs services for sexual violence. Findings suggest that involving CHWs may be beneficial, but potential challenges and harms related to CHW-provided services exist. No different models of CHW-provided care have been robustly evaluated for effects on patient outcomes. Given the large potential for CHWs to address the health burden resulting from sexual violence, further research in this area is desperately needed.

Key words: Sexual violence, community health workers, sexual violence healthcare services, survivors

4.2 Introduction

Sexual violence is widespread globally. Reported lifetime prevalence of partner and non-partner sexual violence in women is as high as 59% and 12% respectively in some regions [9, 11, 115]. Associated health consequences are both short-term and long-term [9, 18, 22, 23, 116-118]. Global clinical guidelines recommend comprehensive immediate healthcare and follow up to address both the clinical and psychosocial needs of survivors [15, 17, 27, 119]. However, the majority of survivors do not access health care and only a limited proportion complete recommended treatment [3-5, 24-26, 33, 37, 38, 41]. Sexual violence stigma at the community level, distance from health facilities, unreliable or unavailable services, healthcare professionals' attitudes and competing priorities for survivors such as work are some of the main barriers to access [41, 43, 120]. Lack of active follow up and social support further hinder treatment completion [4, 41]. Moreover, most services are provided through emergency care or rape care centres, where fear of stigma and being judged may prevent participants from attending [4]. One way to overcome the poor access to healthcare and to treatment completion is to make use of already existing and affordable structures such as community health workers (CHWs) services [44, 121].

The World Health Organisation (WHO) defines CHWs as community-based workers who are members of the communities where they work, selected by their communities, have received limited training but are not professional health workers. They are supported by the health system while not necessarily being a part of its organisation [45]. Community health workers provide a means for communities to access affordable healthcare as well as participate in managing their health [122]. Studies show that CHWs can provide benefits in cost-savings, increasing community involvement, improving clinical outcomes, providing an alternative to professional workforce-limited situations and decongesting health facilities [49].

There have been concerted efforts, particularly in resource-limited settings, to utilise CHWs in the management of different health conditions. Data show the positive impact of CHWs on access to care, clinical, retention and other outcomes in treatment of specific health conditions such as maternal and child health [48], tuberculosis (TB) [123], human immunodeficiency virus/acquired

immune deficiency syndrome (HIV/AIDS) [47, 49, 123] and mental health [124, 125]. A systematic review of community-based HIV treatment in Sub-Saharan Africa for instance, showed that interventions delivered by CHWs could reduce barriers to retention and reduce costs to patients [126].

In this paper, we report the findings of a review to investigate whether CHWs could provide similar benefits in sexual violence healthcare for adults and children. We reviewed different components of CHWs programmes that could potentially influence CHWs performance as well as interactions with survivors. These components included the socio-demographic characteristics of CHWs used, their selection, training provided, roles of the CHWs, mode of service delivery and population served. The review also assessed the acceptability of CHWs services by survivors, the feasibility of delivering such services, as well as the challenges and benefits associated with such services for CHWs, health care systems and survivors.

4.3 Methods

We conducted a systematic review of qualitative and quantitative studies. The review was conducted and reported according to the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines [127] and was registered with the International Prospective Register of Systematic Reviews (PROSPERO).

4.3.1 Inclusion criteria

All studies that reported on services or interventions delivered by CHWs to support prevention of sexual violence, access to healthcare, treatment adherence and retention in healthcare for sexual violence survivors were included. Community health workers were defined based on the WHO definition [45]. Many of the studies referred to these workers as volunteers and therefore the term CHWs and volunteers are used here interchangeably. Sexual violence was defined based on the WHO definition as “any sexual 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” [16].

4.3.2 Search strategy

Seven databases were searched from first record to 08/05/2017: MEDLINE, Africa Wide Information, Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus, Cochrane library, Embase, Global Health and PsychINFO. References of identified studies were also checked for relevant studies. There was no time or language restriction to the studies. A search criteria tailored for each database was developed with the relevant controlled vocabulary terms, Boolean operators and truncation applied to the different databases. The search strategy and number of articles obtained is outlined in appendix 9.

In total, 4,617 records were obtained, saved into an EndNote X7 library and duplicates removed. The remaining 3,901 records were screened on titles and abstracts and irrelevant studies identified excluded from further screening. Full texts were obtained for 24 studies. A further 16 studies were excluded based on the full text review due to various reasons as shown (figure 1). All the titles and abstracts for inclusion were screened by AG; AG and BK read and screened the 24 full text studies.

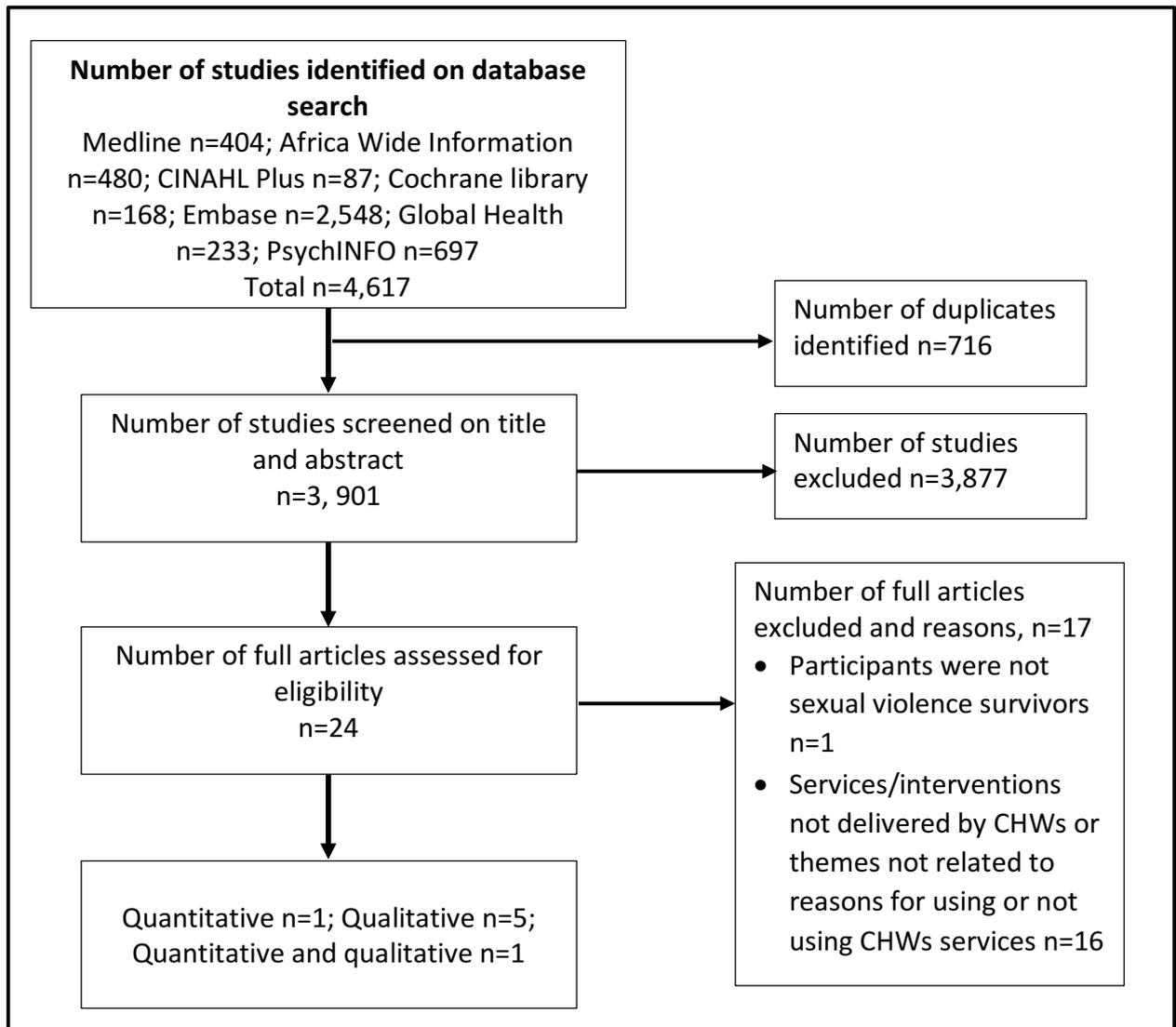


Figure 4.1: Literature search results

4.3.3 Data Abstraction

All information related to supporting prevention, access to care, treatment and retention was extracted. Acceptability and feasibility were assessed through reported willingness to use, satisfaction with services, ease of delivery, quality and uptake of services, availability of resources, adequacy of training and cost-effectiveness of services. Additionally, data extracted included: the type of study design, study setting, participants socio-demographic characteristics, number of participants, study methods including recruitment and retention, outcomes measured and results.

For qualitative studies, all data and themes identified by the author in the paper were abstracted [128]. As our study is exploratory, we took this more inclusive approach to allow more data and themes to be included for analysis [128]. Data were abstracted on data collection methods used including number and composition of group members, consenting process, data processing and analysis, identified themes and findings from the study.

4.3.4 Methodological quality of included studies

Quantitative and qualitative studies were assessed separately for methodological quality. The quality of the studies was considered critically and findings are interpreted in light of this, however, no studies were excluded based on their quality. As the two quantitative studies were vastly different in design (one a longitudinal descriptive study and the other a pre and post-test design) two quality assessment tools were used. Quality assessment tool for quantitative studies developed by the Effective Public Health Practice Project (EPHPP) was used for the pre and post-test study [129] while quality assessment checklist for observational studies (QATSO Score) was used for the longitudinal study [130]. An overall rating of the whole study is normally constituted from all quality domains; however the Cochrane collaboration discourages the assigning of a summary score as this involves assigning weights to different domains which may not be justifiable [131]. For this reason, both quantitative studies were rated on each domain but an overall quality score was not constituted (Appendix 10). Quality assessment for the qualitative studies was done using the methodology checklist for qualitative studies by the National Institute for Health and Clinical Excellence (NICE) [132] and is shown in appendix 11.

4.3.5 Data Analysis and synthesis

Qualitative and quantitative data were analysed separately and the findings combined into a final synthesis. The two quantitative studies reviewed had different aims and outcomes, therefore a descriptive synthesis was performed in lieu of a meta-analysis. For qualitative studies, data were analysed thematically. Key themes relevant to the review questions were identified prior to data abstraction. Other relevant themes emerging from the review process were integrated in the analysis.

Data synthesis from both qualitative and quantitative studies was done through a framework approach [133]. The findings were summarised under the following headings: models of CHWs' services for sexual violence care, acceptability and feasibility of CHWs' services in sexual violence care and the challenges and benefits of CHWs as service providers for sexual violence.

4.4 Results

4.4.1 Characteristics of included studies

Seven studies met the inclusion criteria [40, 65, 134-138]. The studies were conducted in six countries: Democratic Republic of Congo, Rwanda, Burma, United States of America, Scotland and Israel. Of those included, five were qualitative [65, 135-138], one quantitative [40] and one used both quantitative and qualitative methods [134]. Of the five qualitative studies, one was implemented for prevention of child sexual abuse in the community [135], the second described a volunteer advocate support programme for a specific population of the deaf and deaf-blind [136]. The third study described a stand-alone treatment centre for sexual violence which utilised volunteers to provide psychosocial support to survivors [137]. The fourth study described a pilot programme for community-based medical care for survivors delivered by CHWs [65] while the fifth comprised of 44 semi-structured interviews with survivors who were members of local survivors' associations where select members were trained to provide trauma counselling to their peers [138].

The quantitative study was a longitudinal descriptive study that followed up survivors over a one month period and utilized CHWs attached to a mobile clinic at the community level [40]. The mixed methods study involved a pre- and post-test waitlist design with a volunteer-delivered prevention programme. Quantitative methods were used to compare pre- and post-intervention knowledge, skills and occurrence of violence disclosure while qualitative methods were used to assess acceptability and feasibility of the programme [134]. The characteristics of the studies are summarised in table 4.1.

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Author, Year	Country	Study design	Number of survivors	Age of survivors	Socio-demographic characteristics of survivors	Type of services received by survivors	Community health workers (CHWs) service model	Number of community health workers
Kohli, 2012 [40]	Democratic Republic of Congo (DRC)	Observational: Longitudinal follow-up for one month	657 survivors received medical treatment	0.9% below 20 years, 59.6% above 40 years	Females, 3.7% single, 61.9% married, 19.8% separated & 14.6% widowed	Treatment for sexually transmitted infections (STIs) and other diseases, HIV testing, psychosocial support	General CHWs attached to a mobile clinic	Not reported
Tanabe, 2013 [65]	Burma	Qualitative: Focus group discussions with CHWs, traditional birth attendants & community members	No survivor presented	No survivor presented	No survivor presented	Medical treatment of STIs, pregnancy prevention, wound care, psychosocial support & referral	Specialised CHWs providing mobile maternal health care at the community level & trained to provide sexual violence care	Not reported
Barron, 2013 [134]	Scotland	Mixed methods: Experimental pre- & post-test design; Qualitative in-depth interviews	20 included in the study	6-13 years	Intervention group: 4 males, 6 females; comparison group 10 females	Small group training- 4 lessons of 50 minutes duration on child sexual abuse prevention	*Volunteer workers trained in delivering the programme	3 females
Merkin, 1995 [136]	United States of America	# Qualitative: Observations, informal conversations	225 cases	4-76 years: (205 adults & 20 children)	204 females & 21 males; 197 deaf & 28 deaf-blind	Crisis intervention, medico-legal & social support	*Volunteer workers trained in gender-based violence & in supporting survivors	18 females & 2 males
Rossmann, 1999 [137]	United States of America	# Qualitative: Observations, informal conversations	Not reported	Not reported	Not reported	Psychosocial support	*Volunteer workers attached to a community treatment centre	Not reported
Zraly, 2011 [138]	Rwanda	Qualitative semi-structured interviews	44 interviewees	Not reported	Females	Individual & group counselling	*Peer survivor trained in counselling	One female
Itzhaky, 2001 [135]	Israel	Qualitative in-depth interviews & observations	15 child sexual abuse cases identified	Children, age not reported	Children	Counselling	*Volunteer community workers	Not reported

*Volunteers trained to deliver the specific programme but not typical community health workers

Studies did not describe a data collection method such as in-depth interviews or focus group discussions

4.4.2 Methodological quality of quantitative studies

Only two quantitative studies were identified which met our inclusion criteria. One was a longitudinal descriptive study of survivors receiving medical treatment [40]; the other was a small pilot test of a prevention intervention with only 20 participants, which used a pre and post-test design [134]. The quality of the studies is summarised in table 4.2. These are some of the first

studies conducted on this topic and provide valuable information about how participants interact with services. However, the sample size was very small in the pre-post study, and attrition was extremely high in the longitudinal study (perhaps not surprisingly given that it was conducted in a conflict setting). No studies were found that intended to evaluate the effects of a CHWs led intervention on survivor outcomes

Table 4.2: Methodological quality rating of quantitative studies

Study	Rating domain (EPHPP for evaluation studies)							
	Selection bias	Study design	Confounders	Blinding	Data collection methods	Withdrawals and dropouts	Intervention integrity	Analyses
Barron, 2013 [134]	Moderate	Moderate	Weak	Not applicable	Moderate	Strong	Moderate	Moderate
Rating domain (QUATSO for longitudinal studies)								
	External validity		Reporting		Confounding		Bias (Privacy)	
Kohli, 2012 [40]	0		Response rate	Outcome measure	Not applicable		1	
			Not applicable	1				

4.4.3 Methodological quality of qualitative studies

Three of the qualitative studies were scored as having met most of the checklist criteria (++) [65, 134, 138], one was scored as having met some of the criteria (+) [135] and two were scored as having met few of the criteria (-) [136, 137]. The quality assessment was limited by a lack of detail about reported methods, particularly in regards to data collection and analysis. The quality assessment for all the qualitative studies is summarised in table 4.3.

Table 4.3: Methodological quality assessment for qualitative studies

Rating section	Barron, 2013 [134]	Itzhaky, 2001 [135]	Merkin, 1995 [136]	Rossmann, 1999 [137]	Tanabe, 2013 [65]	Zraly, 2011 [138]
1.1 Is a qualitative approach appropriate?	Appropriate	Appropriate	Appropriate	Appropriate	Appropriate	Appropriate
1.2 Is the study clear in what it seeks to do?	Clear	Mixed	Mixed	Unclear	Clear	Mixed
2.1 How defensible/rigorous is the research design/methodology?	Defensible	Defensible	Not defensible	Not defensible	Defensible	Defensible
3.1 How well was the data collection carried out?	Appropriate	Appropriate	Inadequately reported	Inadequately reported	Appropriate	Appropriate
4.1 Is the context clearly described?	Clear	Clear	Unclear	Unclear	Clear	Clear
4.2 Were the methods reliable?	Reliable	Reliable	Unreliable	Unreliable	Unreliable	Unreliable
5.1 Are the data 'rich'?	Rich	Not sure/not reported	Not reported	Not reported	Rich	Rich
5.2 Is the analysis reliable?	Reliable	Not reported	Not reported	Not reported	Unreliable	Reliable
5.3 Are the findings convincing?	Convincing	Not convincing	Not convincing	Convincing	Convincing	Convincing

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5.4 Are the conclusions adequate?	Adequate	Adequate	Adequate	Adequate	Adequate	Adequate
6.1 Was the study approved by an ethics committee?	Yes	Not reported	Not reported	Not reported	Yes	Yes
6.2 Is the role of the researcher clearly described?	Clear	Not clear	Not clear	Not reported	Clear	Clear
As far as can be ascertained from the paper, how well was the study conducted?	++	+	-	-	++	++

4.4.4 Components of CHWs models for sexual violence services

The components of CHWs models reported include the socio-demographic characteristics of CHWs, their selection, training, roles, mode of service delivery and population served (table 4.4). In general, CHWs services were delivered by volunteers trained on the specific intervention. Most were specialised volunteers who only delivered one type of service/intervention and there was no evidence that they carried out any other health-related activities [134, 136-138]. In nearly all cases, the volunteer programmes were run by non-governmental organisations (NGOs) but delivered services in collaboration with government agencies.

Socio-demographic characteristics of CHWs used

Only 3 of 7 studies reported any socio-demographic characteristics of the CHWs. One study reported using only female CHWs aged between 20-30 years [134] while another reported using both females and gay men to serve gay male survivors [136]. A third study described using peers who were female [138]. Even among the studies that reported this information, none reported how these characteristics may or may not have affected the outcomes measured or relationships with survivors.

Selection of CHWs

The selection of the CHWs was reported in 3 of 7 studies. Where reported, the selection appeared to target CHWs with specific skills suited to serving survivors. One study reported selecting the 'highest cadre' of CHWs, defined as CHWs who had previously been trained to provide reproductive health services [65]. These CHWs were therefore deemed already equipped with the skills they needed, for instance to provide emergency contraception to survivors. A second study reported screening volunteers for their ability to understand the importance of confidentiality and sensitivity [136]. A third study described selecting respected community members already known for supporting individuals dealing with grief, rejection and sexual violence stigma [40].

Training of CHWs

The training details for the CHWs were not given in two studies [134, 137]. In the other five studies, the duration of training varied broadly, and there was a lack of detail about the content of training curricula. One study reported a 'workshop type' training on child abuse and incest [135]. The training materials included topics on child abuse, dynamics of abusing families, societal attitudes towards child sexual abuse (CSA), how to communicate with victims and reporting of abuse among others. Two studies reported at least five days training with frequent refresher courses [65, 136]. The topics covered included medical care of survivors, psychosocial support and referral. The fourth study reported 12 weeks of theory and 250 hours of practice on trauma counselling [138] while the fifth only mentioned providing training in the provision of ethical, compassionate and competent care for gender-based violence survivors [40]. None of the studies assessed the effect, duration or the contents of training on any outcomes related to survivors or CHWs.

Roles of the CHWs and mode of service delivery

Different modes of service delivery were reported. In some programmes, CHWs worked at the community level [65, 135, 138] while in others they were based in a facility [136, 137] and yet in others they were involved both at the community and facility [40]. For those based in the community, activities included raising awareness, identifying cases, treatment, providing community feedback to healthcare workers at health facilities and providing psychosocial support including individual and group counselling of survivors. Those based in facilities responded to crisis telephone calls, accompanied survivors to hospitals and the police, provided emotional support and education as well as assisted clinicians in tasks related to managing survivors such as prioritising treatment, setting up appointments and follow-up. One programme had volunteers providing group-training on knowledge and skills for prevention of child sexual abuse to children with previous exposure to violence. The role of treating survivors including wound care, prescribing treatment such as emergency contraception and prophylaxis for sexually transmitted infections was piloted by one study [65]. Although this pilot was carried out for one year and CHWs reported being comfortable providing these services, no survivor was treated and it is therefore difficult to draw any conclusions on the capacity of CHWs delivering medical care to survivors.

Populations served

With regards to populations served, the prevention services targeted prevention of violence in children with interventions delivered to both the community and groups of children [134, 135]. Services and interventions providing medical care and psychosocial support targeted adult women [40, 65]. In some instances, the services were provided as part of a support group formed by survivors and ran by peers [138]. One programme was designed exclusively for a specific population of the deaf and deaf-blind which included both males and females [136]. It is notable however, that the proportion of clients who were males served by this intervention was low (9.3%).

	Socio-demographic characteristics of CHWs	Selection of CHWs	Training of CHWs	Roles CHWs	Mode of service delivery	Population served
Kohli, 2012 [40] Democratic Republic of Congo	Not documented	Respected community members known for supporting neighbours to deal with loss of family, rejection and stigma due to sexual violence.	Training in the provision of ethical, compassionate and competent care for GBV survivors.	Identify & build relationships with survivors & educate them on available services; assist providers in prioritising services; spread the word throughout the village about the mobile clinic visit schedule & encourage women and others to attend	General CHWs attached to a mobile clinic	All survivors of sexual violence
Tanabe, 2013 [65] Burma	Not documented	Highest cadre of CHWs- previously trained to provide reproductive health services	5 days training on care of survivors, 3 day refresher training every 6 months	Conducting medical examination, treatment or preventive treatment for STIs, emergency contraception, care of wounds, supportive counselling & referral	Specialised CHWs providing mobile maternal health care at the community level	No survivors presented during the study period
Barron, 2013 [134] Scotland	3 Female; 20-30 years; working class; adult survivors of child sexual abuse	Not documented	Trained & experienced in delivering the programme- training details not given	Facilitate small group training sessions	Volunteer workers delivering group training	Children
Merkin, 1995 [136] United States of America	18 female & 2 male	Rigorous screening including an interview to determine suitability	50-hour training on gender-based violence & programme delivery; continuous monthly meetings & trainings	Receive calls on the crisis line, educating victims, accompany victims to hospital & police	Volunteer workers attached to a crisis centre	All survivors both male and female who are deaf & deaf-blind
Rossmann, 1999 [137] United States of America	Not documented	Not documented	Not documented	Setting up counselling appointments; provide emotional support to the victims	Volunteer advocates attached to a community treatment centre	Not documented
Zraly, 2011 [138] Rwanda	Female	Not documented	12 weeks theory & 250 hours of supervised practice on trauma counselling	Providing individual & group counselling; assisting with setting up peer support associations	Members of survivor support associations trained to provide counselling	Adult female

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Itzhaky, 2001 [135] Israel	Not documented	Not documented	Workshop-type training on child abuse & incest	Identified cases of abused children, conducted community awareness and group trainings	Community workers/activists not affiliated to the health system	Children
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4.4.5 Acceptability and feasibility of CHWs services in sexual violence care

Assessment of the acceptability and feasibility of CHWs services was limited and equivocal as summarised in table 4.5. Only three studies reported collecting data from survivors on their experience with CHWs services [134, 137, 138]. Survivors in one study found the services useful in improving access to care and providing psychosocial support particularly when hospital services were inadequate for their needs [138]. In the other two studies, programmes delivered by CHWs were reported as likeable and understandable as well as providing non-judgemental and compassionate support [134, 137]. These findings on acceptability are limited by the small number of survivors interviewed. It is also notable that the studies either did not assess or did not report any negative concerns from survivors.

Notably, only one of the studies in the review was designed specifically to assess the performance of CHWs in delivering healthcare services to survivors [65]. In this study, community members interviewed expressed the view that CHWs were trusted members of the community who could be approached by survivors for help. Although the study design included a plan to interview survivors, this did not happen as no survivor presented within the one year study period. The reasons why survivors did not present are not clear, with the authors suggesting possible reasons as no incidence occurring, sensitivity of the subject or lack of awareness of the existence of services. The other studies were designed to assess programmes in which CHWs were a component. As such, reported data focused more on the overall programme acceptability rather than the CHWs. Additionally, reports are mainly from other stakeholders' perspectives and not the survivors themselves thus posing an impediment to the extent that acceptability of the services could be assessed.

Only two studies assessed any aspect of feasibility of sexual violence service delivery by CHWs. Interviewed CHWs reported being comfortable dealing with sexual violence, understanding the

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services they were to provide and the confidentiality required, and having no safety concerns [65]. The second study assessed the cost of delivering the programme and reported it to be minimal due to CHWs being volunteers therefore unpaid [134]. However, this was not a formal costing but an estimate of the cash used to deliver the programme. This study also reported limited preparation time for the CHWs once they had received initial training and gained experience.

Table 4.5: Reported acceptability and feasibility of CHWs in sexual violence services		
	Acceptability	Feasibility
Kohli, 2012 [40]	Not documented- assessment of whole programme rather than CHWs	Not documented- assessment of whole programme rather than CHWs
Tanabe, 2013 [65]	Community members interviewed reported that CHWs are trusted members of society that survivors can seek care from	CHWs demonstrated comfort with the subject of sexual assault and good understanding of medical treatment; CHWs demonstrated full understanding of confidentiality and data collection; Safety was not an issue of excess concern to CHWs
Barron, 2013 [134]	Survivors reported liking the programme & the programme being understandable	Cost of delivery was minimal particularly because the facilitators were volunteers. Training & experience contributed to facilitators spending very little time on preparation
Merkin, 1995 [136]	Not documented- assessment of programme rather than CHWs	No assessment of feasibility documented
Rossmann, 1999 [137]	Rise in the use of volunteer advocates by 75%; feedback from victims of non-judgemental compassionate support provided	No assessment of feasibility documented
Zraly, 2011 [138]	Interviewed women found the services useful and particularly when hospital services were inadequate for their needs	No assessment of feasibility documented
Itzhaky, 2001 [135]	Feeling of trust for community workers developed; Large number of community members becoming involved in the prevention efforts	No assessment of feasibility documented

4.4.6 Challenges and benefits of CHWs providing services for sexual violence

Several benefits and challenges were mentioned (table 4.6). Authors in two studies reported that enhanced community awareness and knowledge as a result of CHWs activities and advocacy resulted in fewer incidences of violence, increased number of survivors taking action to end violence from partners and an increased number of cases of abuse going to trial [135, 136]. Nevertheless, these studies were small and larger prospective studies with control groups are needed to assess the effect of similar interventions over time. Two studies reported feedback from survivors that they received non-judgemental, compassionate and useful psychosocial support from CHWs [137, 138]. Similarly, the authors of one study observed that the programme benefited by having CHWs among their cadre of staff [40]. The CHWs provided feedback that assisted healthcare providers to understand the local concerns which they could then address during health talks or individual treatment. They were also able to mobilise communities and survivors to access the available healthcare which they might have missed without the awareness created.

There were general challenges related to CHWs providing sexual violence services and challenges related to specific models of CHWs. Where CHWs provided other health-related services (general

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CHWs), issues of many responsibilities and high workload were reported [40, 65]. In addition, other commitments that CHWs had, prevented them from delivering the services effectively and in some instances, CHWs were expected to cover vast regions hindering their ability to reach everyone [40].

With regards to sexual violence, some of the CHWs interviewed were uncomfortable with certain aspects of care, (for example, medical care) while others were unclear on how to assist survivors while maintaining confidentiality [65]. In one study, professional healthcare workers and survivors had a problem understanding the role of the CHWs which meant they were not always readily accepted as part of the care team [137]. Additionally, in programmes where CHWs were called in when a survivor presented, the time taken to contact the CHWs and get them to the facility was often long, therefore delaying care for the survivor [137]. One study reported concerns regarding community norms affecting the work of the CHWs who were themselves members of that community [135]. Child abuse was noted as being normative in this community and the CHWs also had difficulties recognising it as abuse.

	Benefits	Challenges
Kohli, 2012 [40]	Authors report that local CHWs assisted healthcare providers in targeting education sessions to community concerns; CHWs provided feedback to healthcare providers e.g. reported increased patient satisfaction	Authors report “travel distance & other commitments sometimes prevented CHWs from reminding patients about appointments and thus, follow-up rates were not as high as expected.”
Tanabe, 2013 [65]	Community reported that CHWs are trusted persons that survivors can approach for help	CHWs reported lacking confidence in history-taking and psychosocial care; ‘Lower cadres’ of CHWs were unhappy with some aspects of medical care & referrals, complained they already had too many responsibilities, had issues with maintaining confidentiality & had some safety concerns
Barron, 2013 [134]	Increased knowledge & skill; Occurrence of disclosures in the intervention group compared to no disclosures in the comparison group; satisfaction with programme; minimal cost of delivery	Not documented
Merkin, 1995 [136]	Increased number of victims taking action on violence in their lives & increase in number of cases of abuse going to trial	Not documented
Rossmann, 1999 [137]	Feedback from victims report non-judgemental compassionate support by volunteers	Time taken to contact the volunteer & get them to the centre to offer support was long delaying care for survivors; Failure of recognition & acceptance by both the victim & professional healthcare workers
Zraly, 2011 [138]	Available care in crisis & source of support	Not documented
Itzhaky, 2001 [135]	Increased community awareness with change of attitude towards child sexual abuse; Reduction in stigma & therefore increased acceptance & support for survivors; Reduced incidence of cases	Child abuse reportedly normative thus community workers not motivated to act initially

4.5 Discussion

To our knowledge, this is the first systematic review of CHWs services for sexual violence against adults and children. This review has identified important gaps in research in this area. Firstly, there was no robust evidence to support any particular model or model components as being effective for the delivery of sexual violence services by CHWs. Secondly, evidence on the acceptability and feasibility of delivering these services is minimal in volume and generally limited in quality. Although there is some evidence suggesting that CHWs provide services for survivors, the experiences of the survivors themselves and CHWs with regards to these services are largely undocumented. Thirdly, in terms of benefits, the studies reviewed indicate a wide range of services provided by CHWs spanning from prevention, treatment, psychosocial support and follow up. However, it is unclear where CHWs provide the maximum benefit or where their knowledge and skills can be optimally utilised. Finally, various challenges were mentioned which highlight the importance of tailoring services to survivor needs, different populations and context and this area requires further exploration.

Our review had several limitations. Firstly, there were limitations related to the included studies. Few studies met the inclusion criteria. Very few survivors or CHWs were interviewed in these studies, therefore the studies mostly represent the views of other stakeholders rather than the actual consumers of services. It is therefore difficult to draw any conclusions on effectiveness of models, acceptability or feasibility of CHWs in sexual violence services. No studies evaluated the effects of any CHW-provided intervention to improve any aspect of sexual violence care. These limitations perhaps reflect the difficulties of conducting research in this topic and highlight the need for innovative ways to recruit and follow up survivors for research. More rigorous research in this area is necessary.

Secondly, there were limitations related to the review. While every effort was made to include as many studies as possible, the term community health worker represents a very broad concept with many different terms used to describe CHWs in different settings. It is possible that some of these terms were not included in our search strategy. We also included studies that did not define their volunteers as CHWs or volunteers who did not fit the typical WHO definition (for instance

belonging to and being selected by the community) as long as they delivered similar services to CHWs.

Despite the limitations of the current evidence base, a number of important findings emerged. Some of the reviewed studies reported that CHWs were trusted members of the community and this trust can enhance their role in awareness raising and mobilisation. This trusted position has enabled CHWs to successfully provide services for other health conditions such as maternal and child health, HIV, TB, malaria, and mental health [44]. Trust is likely to be of key importance for sexual violence, a stigmatised condition; however as our review highlighted, it is also possible that because of stigma and socio-cultural norms, people are reluctant to seek treatment or CHWs do not recognise abuse [135]. This echoes findings of a recent systematic review which found that contextual elements such as socio-cultural factors influenced CHWs performance [139]. While CHWs have been shown to be beneficial in improving uptake of care, quality of life and retention in care for other socially stigmatising conditions such as HIV [121], a study in Uganda found that due to a desire to keep their condition confidential, people living with HIV preferred CHWs who were from a different village [140].

Although not explored in any studies in this review, CHWs could play an important role in increasing access and adherence to HIV post-exposure prophylaxis (HIV PEP) as well as other treatment for survivors such as emergency contraceptive. CHWs have been used to deliver antiretroviral treatment in Uganda and Kenya for HIV-positive people at home thus making treatment more accessible and affordable [126]. In Madagascar, CHWs routinely provide contraceptives and can effectively perform pregnancy tests to inform their decision on contraceptive prescription [141]. Furthermore, a study in South Africa found that providing proactive follow up with flexible follow up locations such as the survivor's home achieved high follow up and HIV PEP completion rates [26]. However, the authors caution that this intervention involved investing substantial resources, particularly the use of trained nurses. Community health workers, with adequate training and clarity of roles, could be a viable substitute to trained nurses in providing this type of proactive follow up in resource-constrained settings. Other studies have also shown that CHWs' characteristics such as a high education level, experience with health condition, social status and supervision are crucial determinants of CHWs performance and these too need to be considered in designing such an intervention [142].

The only programme that reported ease of delivery and minimal costs in programme had very specialised volunteers delivering a specific training intervention to a very small group. This is unlike typical CHWs programmes where CHWs have multiple responsibilities and often have to dedicate more time to their different roles. Some of the reviewed studies reported challenges that impact on the feasibility of CHWs services to survivors including long travel distances, too many responsibilities, lack of recognition and other commitments. These challenges, along with others identified in various studies, are systemic challenges which are not unique to sexual violence but affect CHWs in general, and need to be addressed to improve effectiveness of CHWs [121, 122, 143].

Implications and recommendations for future research

In line with current roles of CHWs, activities that CHWs could be involved in span the whole spectrum of care from primary to tertiary prevention with CHWs carrying out activities to reduce stigma and increase social support at the community level, supportive counselling, providing linkages and referral to services, supporting adherence to treatment and retention in care. Studies need to explore further various indicators of acceptability and feasibility including willingness to use, satisfaction with services, ease of delivery, quality and uptake of services, availability of resources, adequacy of training and cost-effectiveness of services. Furthermore, it is important to consider the model of care (community and facility based, or just community), and the type of services to be offered as these will have an impact on the availability of resources and the type of training required. While the current studies reported both models and a variety of services, there was no assessment on the effectiveness of either models or the training and resources required.

Conclusions

This review points to a potential for CHWs providing support healthcare services for sexual violence but there is lack of quality evidence on appropriate models, acceptability of the services to survivors and feasibility of delivering the services. Improving services for sexual violence survivors through CHWs is only possible if acceptable and feasible models of care can be established. Overall, the studies reviewed were not designed to measure the effectiveness of CHWs services for sexual violence. Further research to establish survivor's views on these services, and the effectiveness of these services, is crucially need

Chapter 5: Research Paper 2. Missed treatment opportunities and barriers to comprehensive treatment for sexual violence survivors in Kenya: A mixed methods study

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SECTION A – Student Details

Student	Anne Gatuguta
Principal Supervisor	Prof Gill Walt
Thesis Title	Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors: A systematic review and case study in Kenya

If the Research Paper has previously been published please complete Section B, if not please move to Section C

SECTION B – Paper already published

Where was the work published?			
When was the work published?			
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion			
Have you retained the copyright for the work?*	Choose an item.	Was the work subject to academic peer review?	Choose an item.

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SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	BMC Public Health
Please list the paper's authors in the intended authorship order:	Anne Gatuguta, Kate Gannett, Janet Seeley, Manuela Colombini, Seyi Soremekun, Karen Devries
Stage of publication	Choose an item. <u>UNDERGOING REVIEW</u>

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	I designed the study with input from Karen Devries, managed the data collection, analysed the data with input from Kate Gannett and drafted the manuscript
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Student Signature: _____

Date: 06/04/2017

Chapter 5: Missed treatment opportunities and barriers to treatment

Supervisor Signature: _____



Date: _____

6. 4. 2017

5.1 Abstract

Background: In Kenya, most sexual violence survivors either do not access healthcare, access healthcare late or do not complete treatment. To design interventions that ensure optimal healthcare for survivors, it is important to understand the characteristics of those who do and do not access healthcare, as well as barriers to comprehensive treatment.

Methods: A mixed methods approach was used. Records for 543 survivors (hospital respondents) were reviewed and key informant interviews conducted with healthcare providers in two referral hospitals. These hospital data were compared with national-level data from the Kenya Demographic and Health Survey 2014, and the Violence Against Children Survey 2010, restricted to those reporting sexual violence. Descriptive summaries were calculated and differences in characteristics of the survivors assessed using chi-square tests. Qualitative data from six in-depth interviews with healthcare providers were analysed thematically.

Results: Among the hospital respondents, the majority 506 out of 543 (93.2%), of survivors presenting were female; single (69.5%); and, knew the perpetrator (71.9%). Over two-thirds (69.2%) were children below 18 years. Nationally, those at higher risk of not accessing healthcare include older survivors; partnered or ever partnered survivors; survivors experiencing sexual violence from intimate partners; children experiencing violence in schools; and men. Gaps identified in the hospitals include missed treatment and poor documentation. Among the hospital respondents, HIV PEP was not given to 30% of survivors. A majority (59%) of those not put on HIV PEP presented late and comprised mainly of children. Forty per cent (40%) of survivors were missing laboratory results for different tests. Those aged 18 years and below and those assaulted by known perpetrators were more likely to miss being put on treatment such as HIV PEP and STI prophylaxis. Qualitative data highlighted challenges in accessing and providing healthcare both at the community and hospital level that included stigma, lack of staff training, missing equipment and poor coordination of services.

Conclusions: Survivors of sexual violence in Kenya face multiple barriers to healthcare, both at the community and hospital levels. Interventions at the community level should target survivors who

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are unlikely to access healthcare and address barriers to early access to care. Staff training and specific clinical guidelines/protocols for treating children and adolescents are urgently needed.

Key words: Sexual violence- healthcare- HIV PEP-Kenya

5.2 Background

Sexual violence is a serious global health problem with significant physical, psychological and social consequences [9, 16, 19, 144]. The World Health Organisation (WHO) recommends that survivors of sexual violence should get immediate comprehensive treatment and be followed up for up to six months [15]. Immediate treatment involves attention to physical injuries, psychological trauma, prevention of unwanted pregnancy and prevention of HIV and other sexually transmitted infections (STIs) [19] [15]. Long-term survivors of sexual violence are at an increased risk of STIs, abortion, anxiety, depression, post-traumatic stress disorder, suicidal ideation and substance use [9, 16, 19] [15]. Furthermore, experiencing sexual violence as a child is associated with negative health outcomes in adulthood including mental health problems, STIs, high risk behaviours such as having multiple sexual partners, unprotected sex, transactional sex and substance use [145-149]. Despite the significant health consequences, research has shown that the majority of survivors do not access healthcare [9, 16, 19, 150] and many of those who do, do not complete treatment [4, 24, 41, 151].

In Kenya, sexual violence is one of the top 10 risk factors for disease burden [152]. National-level data show that 14% of women and 6% of men age 15-49 years have experienced sexual violence in their lifetime [1]. Reported national prevalence is even higher among children and young adults, with 32% of females and 18% of males reporting having experienced some form of sexual violence before the age of 18 years [2]. More than 90% of these survivors do not seek healthcare [1, 2]. The reasons why they do not seek healthcare are not well documented.

Among Kenyan adults, population data suggests that individual-level characteristics such as age, marital status, place of residence, employment status, level of education and whether one has experienced both physical and sexual violence may influence help-seeking from either formal or informal services [1]. From a study on the reasons for the low uptake of services, qualitative interviews with community members and healthcare workers also point to a lack of awareness of available services and community norms that hinder survivors from identifying their experience as sexual violence requiring treatment [7]. Moreover, fear of being blamed and widespread sexual violence stigma prevent survivors from disclosing and seeking services for violence [153]. Among children, being embarrassed and not wanting to embarrass the family; being afraid of getting into

trouble or getting the perpetrator into trouble; services being too far away or an inability to pay for transport or service fees; thinking the violence was not a serious issue or simply not wanting any services are additional barriers [2] .

Among those survivors who seek healthcare, nearly half do not complete the recommended treatment and follow up [4, 5, 92]. Additionally some survivors present to hospital but are not started on some of the recommended treatment [92]. There is limited data on the reasons why so many survivors fail to complete treatment and why some are not started on treatment. A few studies indicate that factors such as limited financial and human resources; lack of training on managing sexual violence; poor coordination of services; poor referral systems; costs to survivors; stigma; and, lack of active follow may contribute [4, 5, 8, 92]. However, these studies are limited in that they generally represent the views of healthcare providers and the views of survivors are to a large extent undocumented.

In order to appropriately target interventions to improve healthcare seeking and treatment completion, a better understanding of why many survivors fail to obtain or complete treatment is required. Little is known about characteristics of survivors who are least likely to access healthcare in Kenya, or about gaps in care for survivors who do present for healthcare. This study therefore aimed to: 1) compare the characteristics of survivors who present for healthcare at two hospitals to those of survivors reporting violence on national surveys; and 2) understand the services provided to survivors who present for healthcare and identify barriers to treatment.

5.3 Methods

Kenya has a six-tiered (level 1-6) healthcare system, with lower level tiers offering basic healthcare services and more specialised services available in higher-level facilities. From September to November 2015, a review of survivor data and in-depth interviews were conducted in a level four hospital (Naivasha Sub-county Referral Hospital) and a level five hospital (Thika Level 5 Hospital). Naivasha Sub-county Hospital is situated within the Nakuru County approximately 90km northwest of the capital city Nairobi and, Thika Level 5 Hospital is located within the Kiambu County, which borders the capital Nairobi to the east. Both facilities ran an outpatient service that attends to walk-in patients, including sexual violence survivors. The two facilities were purposively

selected as they both treat a high number of sexual violence survivors. Additionally, these facilities are presumably fully equipped to offer all the services required by survivors: they have trained medical personnel, all the medicines including HIV PEP, equipped laboratories, required documents and trained counsellors. Lower-level facilities often lack one or more components of the services and therefore, these two hospitals also receive survivors referred from the lower levels.

A mixed methods approach was used. Quantitative hospital data were collected through existing hospital records and qualitative data through in-depth interviews with healthcare providers. The hospital data aimed to establish the characteristics of sexual violence survivors presenting to the facility, the treatment provided and challenges encountered by healthcare providers in the process of treating survivors. Subsequently, the hospital data were compared with population-level data from national surveys to establish if any differences existed between the profile of those survivors reporting violence nationally and those accessing care in the hospitals.

5.3.1 Quantitative data

Hospital data: Data were abstracted from post-rape care (PRC) forms into a standardised excel sheet. The PRC form is filled in for every survivor presenting at the hospital and is used for both medical and legal purposes. It documents the socio-demographic characteristics of the survivor, the nature of the sexual violence act, where it occurred and when, who the perpetrator was, the physical examination findings on presentation, investigations done, results of the investigations, treatment given and referral to any other services [80] . A total of 543 survivor records were abstracted. Once data were abstracted, all the entries were double-checked against each PRC form filling in any missing values. Where missing values or outliers could not be resolved from the PRC form only, other sources such as the counsellor's records and the sexual and gender-based violence (SGBV) register (contains summarised data for all survivors seen at the hospital) were used. Other missing data were extrapolated judiciously. For example, if gender was missing but there was a record of a pregnancy test or contraceptive being issued, female gender was assigned.

Survey data: National data were obtained from the Kenya Demographic and Health Survey (KDHS) 2014 and Violence Against Children Survey (VACS) 2010 [1] [2]. The KDHS 2014 survey interviewed

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both men and women 15-49 years on their lifetime and current experience of sexual violence and help seeking. The VACS 2010 is a cross-sectional household survey of 13 to 24 year old females and males designed to produce national-level estimates of the prevalence of violence against children. The survey data methods for KDHS 2014 and VACS 2010 are described fully in the KDHS 2014 and VACS 2010 reports respectively [1] [2].

Measures: Respondents were classified as having experienced sexual violence if reporting having ever been a victim of one or more behavioural acts of sexual violence (e.g. physically forced to have sex against will, pressured to have sex when sex was unwanted, etc.). Binary variables were used to assess respondents' sex, whether the respondent knew the perpetrator of sexual violence, and whether or not the perpetrator was a current/previous partner. We considered age as a categorical variable. We grouped marital status according to whether the respondent was: currently married or cohabitating; previously married or cohabitating; or single. Finally, we generated a variable with six groupings to consider the place where the violence occurred: at the respondent's own home; the perpetrator's home; someone else's home; while traveling by foot or roadside or bush; school; or at another location (e.g. a party, public event, etc.) (Appendix 12).

Statistical analysis: For hospital respondents, descriptive summaries for survivor socio-demographic characteristics, nature of sexual violence acts and treatment services were computed. To assess missed treatment services for survivors who present in the hospital, we calculated proportions of the services received by age, gender, marital status and type of perpetrator and assessed differences in treatment provision using chi-square or Fisher's exact tests as appropriate. To compare the characteristics of survivors who present for healthcare at the two hospitals to those of survivors reporting violence on national surveys, we appended the following datasets: the male and female datasets from the KDHS 2014, the male and female datasets from the VACS 2010, and our hospital dataset. We restricted our analysis to participants aged 15 years and above, and tabulated the number and percentage who reported having ever experienced sexual violence in each dataset (n=353 hospital respondents, n=1,069 KDHS respondents, n=611 VACS respondents). We assessed differences in characteristics of the survivors using chi-square tests. For three variables examined (age, perpetrator known/unknown, and place where violence occurred), we report p values comparing only two of the three datasets given lack of available data or notably different variable categories used in the third dataset. Analyses were

performed using STATA 14. Participants with missing data were omitted from the analyses where the missing values were present.

5.3.2 Qualitative data

In-depth interviews were conducted with six professional healthcare providers selected purposively. We selected only healthcare providers who provided services directly to the survivors, who interact most with survivors while they are at the facility and are involved in their follow up. Participants were identified with the help of a nurse counsellor who is the hospital's SGBV coordinator. Eligible participants were doctors, clinical officers (COs), nurses and counsellors. In both facilities, the clinicians who treated survivors were COs rather than doctors. Clinical officers are not qualified as doctors but they are trained to independently provide clinical care to patients, and they provide similar services to those provided by general practitioners. Both male and female healthcare providers were interviewed. Two trauma counsellors, two clinical officers and two nurses were selected. Although every effort was made to recruit healthcare workers, few were interviewed due their restricted availability while also providing services to patients, and the limited duration for the study. Topic guides were used to explore healthcare providers' views on characteristics of survivors; barriers to survivors seeking and completing care; and, challenges of providing services to survivors (Appendix 4).

Interview procedures: AG conducted all the interviews in a private room within the hospital. All interviews were conducted in English. Written informed consent was obtained from all participants. All interviews were audio-recorded with permission from interviewees and lasted for about 30-60 minutes.

Data analysis: Interviews were transcribed verbatim and checked against recordings. The transcripts were then imported to NVivo 11 software. Data were analysed thematically [106]. Initial themes and codes were developed by AG based on study objectives and literature review, and were reviewed by KD. During coding, any emerging new ideas and concepts from the data not categorised previously were given new themes and codes. Once data were coded, the materials with similar codes were sorted and grouped together through thematic matrices with categories and sub-categories under the main themes.

Ethical approval

Ethical approval was obtained prior to commencement of the study from the institutional ethics review committees of the London School of Hygiene and Tropical Medicine (Ref. 9896) and Kenyatta University (Ref. PKU/386/E32).

5.4 Findings

5.4.1 Socio-demographic characteristics of survivors presenting for treatment (hospital respondents)

The socio-demographic characteristics of survivors presenting at the two hospitals are summarised in appendix 13. The majority, 506 out of 543 (93.2%) were female. The mean age was 16.8 years, with the majority (69.5%) being children below 18 years (range 1-67 years). Among adult survivors whose marital status was documented (n=177), the majority were single 123 (69.5%), followed by married 32 (18.1%), separated 8 (4.5%), widowed 7 (3.9%) and divorced 7 (3.9%).

In majority of the cases, 461 out of 530 (87%), only one perpetrator was reported. The incidence occurred in the perpetrator's home in 183 out of 407 (45%) of the times, followed by the roadside or bush 83 (20.4%), and in survivor's own home 71 (17.4%). Most, 387 out of 538 (71.9%), of the survivors knew the perpetrators. Neighbours 30.6%, friends 17.3% and relatives 16% were among the most common known perpetrators of violence. Cases of adolescent girls willingly engaging in sex with their boyfriends and sometimes leaving home to cohabit with them accounted for a significant proportion (15.3%) of those treated. As these girls had not reached the legal age of consent, parents brought them to the hospital as cases of statutory rape.

The age and gender of respondents in the two hospitals were similar but survivors differed in marital status, type of perpetrator, number of perpetrators and place of violence (Appendix 13).

5.4.2 Socio-demographic characteristics of hospital respondents compared to survivors reporting violence in KDHS 2014 and VACS 2010

For congruency, this analysis was restricted to respondents aged 15 years and above, as the KDHS 2014 did not collect data for children below 15 years.

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Gender: The proportion of men reporting violence nationally differs significantly to those seeking healthcare at the hospitals (Table 5.1). While only 4% of those presenting for treatment are men, 28% of the KDHS respondents and 39% of VACS respondents reporting sexual violence are men ($p < 0.001$). This translates to only one man for more than twenty women among survivors who seek healthcare, compared to nearly one man for every three women reporting violence nationally.

Age: The age profile of survivors reporting violence in the hospital data also contrasts sharply with national reporting of violence, suggesting that older survivors are less likely to seek healthcare compared to younger survivors. While the hospital data indicate that children 15-19 years constitute the highest proportion of survivors presenting for care (57%), KDHS 2014 data show that adult survivors are more likely to report violence ($p < 0.001$). For instance, only 6.5% of those reporting violence are 15-19 years with the highest proportion of survivors being 25-30 years (23%), followed by 30-34 years (18%) and 35-39 years (16%). Similarly, while more than 20% of survivors who reported violence in the KDHS 2014 are 40 years and above, less than 5% of those presenting for healthcare fall in this age group. It is possible that these differences may be due to adults reporting incidences of violence that occurred during their childhood hence higher reporting but less treatment seeking. However, the fact that the national survey also shows that most survivors are currently married/cohabiting and the majority are assaulted by current/previous intimate partners- incidences that likely occurred in adulthood- suggests that the low numbers of adults in hospital are more likely due to failure to seek treatment.

Marital status: Among the hospital respondents, never married survivors were more likely to present for treatment while currently married/cohabiting survivors were more likely to report violence nationally ($p < 0.001$). Among the KDHS respondents, the proportion of never married survivors was 11%, currently married/cohabiting 70% and previously married/cohabiting 18%. In contrast, survivors seeking healthcare were overwhelmingly single (84%), compared to currently married/cohabiting (10%) and previously married/cohabiting (7%).

Perpetrators of violence: There were differences in the type of perpetrators reported by the national surveys respondents and hospital respondents. Hospital respondents were more likely to be assaulted by strangers (66%) compared to VACS respondents (54%) ($p < 0.001$). Current and past

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intimate partners were the highest reported perpetrators of violence among VACS and KDHS respondents but represented less than 19% of perpetrators among hospital respondents ($p < 0.001$). Notably, among hospital respondents reporting violence from intimate partners, a majority (76%) were adolescents who reported the sexual encounter as consensual but were brought to the hospital by disapproving parents as cases of statutory rape.

Place of violence: The place where violence occurred was reported only among hospital respondents and VACS respondents. However, not all of these respondents reported this; these data were missing among 27% and 40% of hospital and VACS respondents respectively. Among hospital respondents with data, violence occurred most commonly in the perpetrator's house (43%), followed by while travelling on foot, by the roadside or bush (25%). Among the VACS respondents, school was the most common place of violence (21%) followed by travelling on foot, roadside or bush (19.1%). Although most hospital respondents are of school-going age (15-19 years), it is surprising that violence reported to have occurred in school was very low (less than 1%) compared to the VACS.

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Table 5.1: Characteristics of participants ages 15+ reporting having ever experienced sexual violence across hospital, Violence Against Children, and Kenya Demographic and Health surveys

		Hospital Respondents	2010 VACS Respondents	2014 KDHS Respondents	p value
Total [^]		353 (100%)	611 (29.0%)	1,069 (10.1%)	
Sex	Male	15 (4.3%)	240 (39.3%)	301 (28.2%)	<0.001
	Female	338 (95.8%)	371 (60.7%)	768 (71.8%)	
Age (n=297 hospital respondents)	15-19	169 (56.9%)	272 (44.5%)	69 (6.5%)	<0.001*
	20-24	49 (16.5%)	339 (55.5%)	163 (15.3%)	
	25-29	39 (13.1%)	//	250 (23.4%)	
	30-34	20 (6.7%)	//	194 (18.2%)	
	35-39	6 (2.1%)	//	172 (16.1%)	
	40-44	6 (2.1%)	//	122 (11.4%)	
	45-49	3 (1.0%)	//	81 (7.6%)	
Marital status (n=338 hospital respondents; n=610 VACS respondents)	Currently married/cohabitating	32 (9.5%)	184 (30.2%)	753 (70.4%)	<0.001
	Previously married/cohabitating	22 (6.5%)	34 (5.6%)	197 (18.4%)	
	Single	284 (84.0%)	392 (64.3%)	119 (11.1%)	
Perpetrator known? (n=349 hospital respondents)	Yes	119 (34.1%)	282 (46.2%)	//	<0.001**
	No	230 (65.9%)	329 (53.9%)	//	
Relationship of perpetrator to survivor (n=291 hospital respondents; n=289 VACS respondents)	Current/previous partner ^{^^}	54 (18.6%)	147 (50.9%)	589 (55.1%)	<0.001
	Other	237 (81.4%)	142 (49.1%)	480 (44.9%)	
Place where violence occurred (n=257 hospital respondents; n=366 VACS respondents)	Own home	41 (16.0%)	68 (18.6%)	//	<0.001**
	Perpetrator's home	110 (42.8%)	54 (14.8%)	//	
	Someone else's home	12 (4.7%)	20 (5.5%)	//	
	Traveling by foot/roadside/bush	65 (25.3%)	70 (19.1%)	//	
	School	1 (0.4%)	77 (21.0%)	//	
	Other	28 (10.9%)	77 (21.1%)	//	

Abbreviations: VACS=Violence Against Children Survey, KDHS= Kenya Demographic and Health Survey

Notes: p values assessed using chi-squared tests.

* p value comparing Kenya Demographic and Health Survey respondents with hospital respondents only.

**p value comparing Violence Against Children Survey respondents with hospital respondents only.

[^]Represents the proportion of respondents for each dataset who report having ever experienced sexual violence.

^{^^}For hospital respondents reporting violence by current/former partner, 41 of 54 (76%) were children below 18 years and believed that the sexual encounter with the boyfriend/girlfriend was not coerced; the parent, however, reported the encounter as coerced and took them for treatment.

5.4.3 Quantitative findings on services provided to survivors in the hospital and barriers to treatment

Similar treatment services were offered in the hospitals in accordance with national treatment guidelines [80]. The services comprised of an initial medical history and physical examination; specimen collection and laboratory tests; treatment; and, counselling. The tests done included screening for STIs such as HIV, syphilis and hepatitis B; a pregnancy test; urine and high vaginal

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swab microscopy; haemoglobin and liver function tests. The treatment recommended in both hospitals includes HIV PEP, emergency contraceptive (EC), STI prophylaxis, anti-tetanus and hepatitis B vaccines as needed. In Naivasha Sub-county Hospital, the services were offered across different departments (outpatient, casualty, HIV comprehensive care centre, Youth centre, and Pharmacy) situated in separate buildings, ranging from a few metres to over 100 metres apart. In Thika Level 5 Hospital, all services were provided at the HIV comprehensive care centre (except at night and weekends when services were offered in the outpatient department). The HIV comprehensive care centre comprised of two buildings adjacent to one another with different services offered in separate rooms.

Missing clinical examination findings and laboratory test results: Missing reports of clinical findings and laboratory tests results were common (Appendix 14). It was not clear from the records whether the absence of these reports was due to the services not being offered or due to failure to document the services. Physical examination findings were not documented in 5% of the survivors, psychological assessment in 14% and genital exam in 2%. In some cases, examination findings documented were very broad and/or uninformative and therefore unlikely to be useful in evaluating a patient clinically or as forensic evidence. For instance, in 46% of survivors, genital exam was reported only as “hymen broken” with no details to indicate whether this was a fresh injury or not and whether there were any other relevant genital findings suggestive of sexual violence.

Failure to carry out laboratory investigations and/or to document results was particularly prominent. None of the laboratory tests had complete records: 40% HIV, 42.2% urinalysis, 40.3% swab microscopy, 43.3% VDRL and 50.4% Hepatitis B had no results.

HIV PEP, other STIs prophylaxis and emergency contraception: Review of records indicated that some survivors presented to the hospitals but failed to obtain certain components of the recommended treatment (table 5.2). According to the national treatment guidelines, all survivors presenting within 72 hours of assault and who have a significant risk of HIV exposure (such as those with oral, vaginal and anal penetration) are eligible for HIV PEP. Among all survivors presenting at the two hospitals, 30% did not receive HIV PEP. The likelihood of not being put on HIV PEP was associated with the age of survivor ($p < 0.001$), whether the perpetrator was known or

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unknown ($p < 0.001$) and the relationship of the survivor to the perpetrator ($p = 0.002$). Children aged 18 years and below were more likely to miss being put on HIV PEP (37%) compared to survivors above 18 years (14%). Survivors where the perpetrator was known were also more likely to miss being put on HIV PEP (38%) compared to survivors where the perpetrator was unknown (11%). Among those who were not put on HIV PEP, the most common reason for not being put on HIV PEP was late presentation (59%). Among children 18 years or below, 67% of those who did not get HIV PEP presented late. Compared to adults, children were more likely to present late with 93% of all survivors who were not put on HIV PEP because of late presentation being children 18 years or below ($p = 0.001$). Survivors where the perpetrator was known were also more likely to miss HIV PEP because of late presentation (62%) compared to survivors where the perpetrator was unknown (27%). Notably, 24% of all survivors who did not get HIV PEP presented within 72 hours and no reasons were documented for not starting them on HIV PEP.

Prophylaxis for other sexually transmitted infections was given in 84% of all survivors. Other than whether a perpetrator was known or unknown ($p = 0.002$), no other survivor characteristics were associated with being put on STI prophylaxis. Among women whose records documented whether EC was given or not, 57% received EC. Single women were more likely to receive EC ($p = 0.027$) compared to previously partnered or married women. Although reasons why EC was not given were not documented, this may reflect the fact that married women are more likely to be on a regular contraceptive method. Similarly, women where the perpetrator was unknown were more likely to receive EC compared to women where the perpetrator was known ($p = 0.001$).

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Table 5.2: Treatment provided to survivors presenting at hospitals by age, gender, marital status and perpetrators of violence

	Treatment provided to survivors											
	HIV PEP given		Late	Reason why HIV PEP was not given			STI prophylaxis given		EC given			
Survivor characteristics (n=543 [†])	Yes	No		Known HIV-infected	Boyfriend/denies sex	PEP not indicated*	No reason given	Yes	No	Yes	No	
All survivors	361 (69.7)	157 (30.3)	92 (58.6)	3 (1.9)	9 (5.7)	15 (9.6)	38 (24.2)	406 (83.7)	79 (16.3)	209 (56.8)	159 (43.2)	
Age	</= 18 years	201 (63.2)	117 (36.8)	78 (66.7)	1 (0.8)	7 (6.0)	12 (10.3)	19 (16.2)	247 (81.5)	56 (18.5)	109 (56.2)	85 (43.8)
	> 18 years	126 (85.7)	21 (14.3)	6 (28.6)	1 (4.8)	2 (9.5)	1 (4.8)	11 (52.4)	117 (88.6)	15 (11.4)	79 (61.7)	49 (38.3)
	P value	0.001										
Gender	Male	23 (67.6)	11 (32.4)	8 (72.7)	0	0	0	3 (27.3)	22 (75.9)	7 (24.1)	N/A	N/A
	Female	338 (69.8)	146 (30.2)	84 (57.5)	3 (2.1)	9 (6.2)	15 (10.3)	35 (23.9)	22 (75.9)	7 (24.1)	209 (56.8)	159 (43.2)
	P value	0.788										
Marital status	Single	96 (80.7)	23 (19.3)	8 (34.8)	3 (13.0)	1 (4.4)	1 (4.4)	10 (43.5)	91 (83.5)	18 (16.5)	69 (65.1)	37 (34.9)
	Married	28 (87.5)	4 (12.5)	0	0	1 (25.0)	1 (25.0)	2 (50.0)	25 (83.3)	5 (16.7)	9 (33.3)	18 (66.7)
	Divorced/widowed	17 (81.0)	4 (19.0)	1 (25.0)	0	0	2 (50.0)	1 (25.0)	16 (88.9)	2 (11.1)	8 (44.4)	10 (55.6)
	P value	0.401										
Type of perpetrator	Known	230 (62.0)	141 (38.0)	88 (62.4)	2 (1.4)	9 (6.4)	14 (9.9)	28 (19.9)	283 (80.6)	68 (19.4)	129 (51.2)	123 (48.8)
	Unknown	128 (89.5)	15 (10.5)	4 (26.7)	1 (6.7)	0	1 (6.7)	9 (60.0)	121 (92.4)	10 (7.6)	79 (69.3)	35 (30.7)
	P value	<0.001										
Relationship to perpetrator	Relative ^a	21 (44.7)	26 (55.3)	18 (69.2)	0	0	0	8 (30.8)	32 (74.4)	11 (25.6)	8 (30.8)	18 (69.2)
	Neighbour	61 (65.6)	32 (34.4)	18 (56.3)	1 (3.1)	0	7 (21.9)	6 (18.7)	67 (78.8)	18 (21.2)	26 (50.0)	26 (50.0)
	Friend ^{aa}	38 (74.5)	13 (25.5)	8 (61.5)	0	0	1 (7.7)	4 (30.8)	45 (90.0)	5 (10.0)	26 (70.3)	11 (29.7)
	Boyfriend ^{aaa}	18 (40)	27 (60.0)	16 (59.3)	0	7 (25.9)	4 (14.8)	0	31 (73.8)	11 (26.2)	15 (33.3)	30 (66.7)
	Current/former husband	7 (77.8)	2 (22.2)	0	0	1 (50.0)	0	1 (50.0)	6 (66.7)	3 (33.3)	5 (55.6)	4 (44.5)
	Other ^{aaaa}	31 (57.4)	23 (42.6)	15 (65.2)	0	0	1 (4.4)	7 (30.4)	47 (87.0)	7 (13.0)	22 (64.7)	12 (35.3)
	P value	0.002										

Abbreviations: HIV PEP= HIV post exposure prophylaxis; EC= Emergency contraceptive

[†] Number of survivors analysed for different treatment given varies due to missing data

* Reasons for HIV PEP not indicated included non-penetrative violence, condom used

^aRelative includes fathers, uncles and cousins

^{aa} Friend includes non-intimate friends and acquaintances such as classmates, co-workers

^{aaa} Boyfriend: Intimate partners to children below 18 years who were in consensual relationships which are not sanctioned by parents therefore brought for treatment as sexual violence

^{aaaa} Others: Includes teachers, priests, boda boda (motorcycle) taxi drivers, watchmen etc.

5.4.4 Qualitative findings on socio-demographic characteristics of survivors

Healthcare providers' (HCPs) views expressed during the interviews helped to explain some of the observed differences between survivors presenting at the hospitals and those reporting violence nationally.

Stigma and socio-cultural norms influence the type of survivors seeking healthcare:

Sexual violence stigma influenced the type of survivors presenting at the hospitals. According to HCPs, men were under-represented among the survivors treated compared to the numbers in the community as men were afraid of identifying as survivors at the community level. The HCPs observed that stigma at the community level also affected adult females. A culture of blaming women for provoking the violence through dressing skimpily, being in the wrong place or through their work prevented them from disclosing and seeking treatment.

*“They [men survivors] are there but they do not come. Because, there is that stigmatisation and that fear of how the community is going to portray you.”
(Professional healthcare provider, HCP3)*

“Ok some people relate it [violence] with your job. Probably you are a bar maid, so even if you are raped they usually take it that you are the one who provoked the perpetrator. And then again, also some in the community, how you dress. They tell you now you are the one who attracted the perpetrator to you. How can you dress skimpily and you expect people to respect you even on the roads?” (Professional healthcare provider, HCP5)

Healthcare providers reported that most of the survivors were from disadvantaged and poor backgrounds. They were also more likely to come from particular communities within the hospital's catchment area. The fact that survivors were more likely to come from certain areas could have implications on sexual violence prevention. Cultural norms and the status of women in society were reported as predisposing factors to sexual violence in these areas. Survivors from such areas were likely to present for treatment only after multiple incidents of violence and many other cases in such areas were unreported.

“Let me say the community that lives there [an area where many of the survivors come from], the men, they don't value so much a woman according to what they tell me. They consider a young person, a young woman, a young girl as a wife. So

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anytime there is a case that happens, when they come, they report that it's something that has been going on for a while [...]. The other reason is they [the women] are also not learned. They don't have the knowledge of their sexual and reproductive health rights." (Professional healthcare provider, HCP3)

HCPs therefore highlighted the importance of community awareness in improving healthcare seeking and follow-up. There was reported lack of general awareness on sexual violence in the community and lack of awareness of available services and where to find them. The lack of awareness is also compounded by the level of stigma in certain communities. HCPs observed that awareness creation would enable survivors to present for care by reducing community stigma and also being aware of the available services and the importance of seeking and completing treatment.

"The awareness needs to be raised so that people don't feel that it's awkward to go to the hospital when you're sexually assaulted. Because, in as much as I've said it's not there [stigma], there is still some component of it in the village, especially in the village because those who come directly, most of them are from the town. That means they're more enlightened or maybe they're educated, now they know but people from the village they think different [...] So, campaigns to raise awareness through the community health workers, something of the sort." (Professional healthcare provider, HCP1)

Types of perpetrators: The profile of perpetrators as reported by healthcare providers mirrored that observed among hospital respondents' quantitative data. Interviewed healthcare providers elaborated on the kind of perpetrators reported and the circumstances in which violence took place. Reported perpetrators were mostly well known particularly in children and adolescents. Grooming in young children was reported as the main reason why children did not report violence as the perpetrators enticed children with gifts often building a relationship over time before the actual sexual act. In contrast, adolescents were often taken advantage of in circumstances where they had diminished capacity to make decisions.

"They [perpetrators] are of course people well known especially to the children and even I have realised, even to adults. Occasionally you will get those who do not purely know the survivors, but especially in adolescents, majority of them they know the survivors, they are their friends, they go for parties in company of others,

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when they are drunk, they are taken advantage of [...]. Even in children because when they come, those ones of a young age, they will talk of uncle or even a relative and not uncle in quotes but a real uncle. Others step fathers, occasionally even a father. We had a young girl, a Form Two student who was sexually abused by the father.” (Professional healthcare provider, HCP4)

Quantitative findings indicated that some adolescents were treated as sexual violence survivors even though they reported being in consensual relationships, sometimes even cohabiting with the alleged perpetrators. During follow up informal discussions to clarify this, HCPs observed that some of the adolescents were brought to hospital by parents/guardians who did not approve of these relationships. As the adolescents had not reached the legal age of consent, they were brought as cases of statutory rape. Parents could then use evidence obtained from hospital to prosecute the alleged perpetrator and stop the relationship.

5.4.5 Qualitative findings on barriers to accessing and receiving quality treatment

Interviewed HCPs provided some insight to the process of getting treatment once at the hospital, reasons as to why some expected treatment might not have been given as well as challenges associated with providing treatment.

Late presentation: HCPs reported that survivors gave various reasons for presenting late—the most common reason for not getting HIV PEP—such as distance, cost of transport to get to the hospital, fear of disclosure and threats from the perpetrator. Late presentation was particularly common in children, as children often did not disclose the abuse immediately due to fear and abuse was often discovered after complications set in.

“The main challenge is the children. Because you see most of the times after the ordeal has happened, these children are threatened. They don’t talk about it until maybe much later when the parent or the guardian may realise there is a problem, or maybe immediately the guardian may realise am seeing some funny behaviours or I can see there is something wrong with my child and they try to peruse and they will come out with the information. But if not very severely damaged, these children will keep quiet. You know most of the times, they say they are enticed, they are given gifts, they are given biscuits and all that. So they don’t really talk about it [...]. So that is why some of these children will come late and they don’t get the services as required.” (Professional healthcare provider, HCP4)

Poor coordination of services: Facility-related challenges were also identified that hindered efficient treatment of survivors once at the hospital. Survivors being attended to at different service delivery points, in different buildings resulted not only in delays but also survivors being lost along the in-hospital pathways.

***Interviewer:** Are there situations where they don't get there [counselling department]?*

***Respondent:** "Yes there are situations. Because, the ones who don't go are the ones who have come and we [clinicians] have seen them, have filled the forms, but have been kept waiting for long hours in the outpatient department. They feel frustrated. And they have that mentality that if I go to the other centres am being sent to, I will still wait the way I have just been waiting in the outpatient department." (Professional healthcare provider, HCP3)*

Despite the fact that there was hospital policy that survivors should be treated as soon as possible without waiting in queues, survivors were still kept waiting for a long time in some service delivery points. Various reasons contributed to survivors waiting and included clinicians being busy with other patients and lack of a commitment by staff in some departments to fast-track survivors.

"Timeliness is still an issue. Because, we are really not seeing them with the speed that we would like to see them with. Maybe delays have been caused, maybe the survivor is supposed to see a clinical officer and maybe the clinical officer is attending to another patient [...]. We are also seeing delays sometimes in the lab. In the casualty department I am having challenges as at now [...] they [doctors] are saying these are not real emergencies, so they are saying unless that survivor comes in bleeding, there are tears and all that. So the doctors I have are not ready to serve these survivors readily. And I guess the whole issue comes in now with the filling of the P3. Not the P3, the PRC forms where they say there is a lot of work, you are seeing this patient and now sitting down here and filling all this information." (Professional healthcare provider, HCP2)

Lack of equipment: Lack of necessary equipment to carry out comprehensive management such as speculums and rape kits was also a hindrance to survivors' care. Furthermore, there were occasions when HIV test kits were missing and survivors were forced to buy them. This could perhaps explain the fact that 40% of survivor records did

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not have swab and HIV results. The lack of equipment limited the quality of care that could be provided to survivors. Lack of speculums, for instance, limited the ability of clinicians to collect quality specimens necessary for both treatment and forensic evidence.

“Sometimes we lack even the kits [HIV test], like now it’s only me who has them. I only have a few, so if they want to test, like now this lady who was here [another counsellor] they come for them [...]. Sometimes we don’t have. [...]. We tell them [survivors] to do it outside and come with results.” (Professional healthcare provider, HCP6)

“Well, challenge with speculums, they aren’t enough. There are times you may go for a speculum and you are told right now we don’t have. So you’ll keep the patient waiting and, some clinician’s do it [high vaginal swab] without, which really should not be the case. It’s a malpractice because if you do it without a speculum, you are likely to even introduce more infections and the results also can be affected by that.” (Professional healthcare provider, HCP2)

Few trained HCPs: Limited training was noted as a major hindrance to providing quality services to survivors. In two departments at the forefront of survivor’s care, HCPs estimated that only about three of approximately 13 staff working in the department were trained to handle survivors. This shortage limited the number of staff members who were confident in managing the survivors, impacting negatively on the treatment of survivors. In some instances, survivors had to wait for a particular individual to receive certain services.

“I think what we can do is, one we need CMEs [continuous medical education] and workshops. At least all health workers should know what to do to such clients because if we all depend on [name of colleague] that she is the one who has done sexual based violence, she can be able to do 1, 2, 3. It will be quite hard. Because some people- right now, at least I am better off because I went for a workshop once for gender-based violence. But you see some people have not, and you know I also won’t be at work throughout.” (Professional healthcare provider, HCP5)

Moreover, although children were the most common survivors, none of the HCPs had training on dealing with child survivors.

Lack of follow up: The hospitals did not have a formal way of following up survivors to ensure that they returned to complete their treatment. Healthcare providers estimated that only about 30-50% of survivors came back after the initial treatment. The HCPs noted that they were limited in their ability to carry out the role of following up survivors. Instead, this would only be possible through involving other players at the community level such as community health workers.

“As a clinician I think it would only be possible [to follow up] if the community is involved. Because as a clinician I don’t think I can be able to follow up anyone unless I have special interests, unless I want to. Because even the other patients the general patients, I don’t get to know what happened to them unless I have a special interest.” (Professional healthcare provider, HCP1)

5.5 Discussion

Three key findings emerged from this study: 1) Certain groups of survivors reporting violence nationally are unequally represented in seeking treatment; 2) within health facilities, various gaps exist leading survivors to miss out on essential treatment even after presenting for care; and, 3) while children below 18 years form a disproportionately large proportion of survivors presenting to hospitals, there are exceptional limitations to children’s services.

5.5.1 Discrepancies in survivors reporting violence nationally and those presenting for treatment in hospital

Although national survey data show that reporting of violence increases with age and older survivors are more likely to report sexual violence [1], our hospital data seems to contradict this. Together with multiple other studies in Kenya [3-5, 8, 92], our data show that children are more likely to present for treatment in hospitals. Moreover, the proportion of male survivors presenting for care is low compared to the proportion reporting violence, indicating that the vast majority of men who experience sexual violence do not seek healthcare. The reasons why older female survivors and men in Kenya fail to seek healthcare are not clearly documented, however, our qualitative data from HCPs suggests that stigma is a significant reason. Studies on healthcare seeking for

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sexual violence, especially in men, in the African setting are limited. One study has similarly identified stigma and shame as well as other barriers such as costs for care and limited availability of services as contributing factors to men missing out on treatment [154]. However, this study was done in a conflict zone and more studies are needed in the local context. Efforts to identify those affected but not receiving treatment as well as targeted services for men are needed.

The current quantitative data also suggest that survivors experiencing intimate partner sexual violence may not be seeking healthcare in most cases. Population-level studies consistently indicate that the most common perpetrators of forced sex in both women and men are intimate partners [1, 28, 155]. The low number of survivors of intimate partner sexual violence seeking healthcare in Kenya is not surprising given the pervasive culture of acceptance of partner violence among women, stigma and a legal framework that does not recognise marital rape as a crime [69, 72, 75, 156]. Nevertheless, the apparent high levels of survivors of intimate partner sexual violence not accessing healthcare is of immense concern when considered in light of health consequences, such as HIV transmission. A Kenya National AIDS Control Council report indicates that majority of new HIV infections occur among married or cohabiting couples [157]. Moreover, many of the HIV-infected couples are in discordant relationships where only one partner is infected [158, 159]. With forced sex, survivors in such relationships are at a heightened risk of HIV infection. Overall, evidence shows that IPV increases the risk of HIV acquisition among women by 50%, not only through forced sex but also other indirect pathways [160]. Specific efforts to reach these survivors should explore alternative and culturally acceptable interventions that address the community norms while providing the necessary information and linkages to care. Notably, while IPV is likely to be a chronic problem and involve different forms of violence, the services currently available at the hospitals are set up to respond to acute cases of sexual violence and no guidelines exist on dealing with IPV.

5.5.2 Gaps in healthcare services

The HIV PEP initiation rate in our study (70%) is consistent with previous studies that have documented rates of HIV PEP initiation ranging from 63-94% [3-5, 92]. However, the fact that 24% of survivors presented to the hospital within the recommended 72 hours but were not put on HIV PEP is of great concern. The reasons for failing to be put on HIV PEP are unclear and require further investigation. Kenya is a country with high (5.6%) HIV prevalence [159] and sexual violence represents a significant risk factor for HIV acquisition [21]. Hence, the need to start all survivors with potential exposure to HIV on prophylaxis is clear. It was notable that failure to be put on treatment for HIV PEP and other STIs was associated with certain survivor characteristics such as age, whether the perpetrator was known or unknown, and the perpetrator relationship to the survivor. While these findings may suggest that healthcare providers may be considering these characteristics when prescribing treatment, the national guidelines do not recommend using survivor characteristics as determinants for or against treatment. These findings therefore point to an area that needs to be addressed in order to ensure that all survivors receive the recommended treatment.

The need to streamline services within the hospital is also highlighted. To begin with, survivors need to attend several service delivery points in the facilities. Previous local research has shown that this can cause delays and even loss of survivors within facilities [4, 5]. Care for survivors is better when all the services are offered at one place [17, 91, 161, 162] [15]. In this study, we found that one of the hospitals provided services at a more centralised location while services in the second hospital were offered in different buildings. We did not have sufficient information to assess the differences between these two models in terms of time survivors took accessing treatment and effects on follow up. However, in-depth interviews with HCPs indicated delays and lack of coordination across service delivery points and this should be addressed.

Qualitative data also indicates a great need for capacity building of HCPs. Very few HCPs interviewed had received any form of training on sexual violence care. WHO recommends that all healthcare providers attending to survivors should receive training not only on the clinical management of survivors, but also on relevant legal and policy guidelines as well

as ethical issues such as confidentiality and reporting requirements [162] [15]. Data also showed incomplete documentation of clinical findings, laboratory investigations and treatment. Poor documentation is detrimental to both the clinical management of the survivor and for forensic evidence. Test results are especially important in making decisions on what treatment to give, for follow up of the survivor and some as legal evidence if the case goes to court. There is an urgent need of training more providers to ensure timely and quality care.

5.5.3 Limitations in services for children and adolescents

Children below 18 years constitute the vast majority of survivors being treated in the two hospitals, consistent with other studies done locally [3-5, 8, 92]. Of great concern is the fact that, although children constitute the highest proportion of those being treated, according to the VACS 2010 report, more than 90% of children who experience sexual violence do not access healthcare [2]. In addition, the current study shows that many of those children who presented failed to get the necessary treatment because they presented much too late for some of the treatment to be effective. These findings are a major cause for concern given the potential long-term effects of sexual violence on children.

While children and adolescents constitute a majority of survivors being treated, there are no services tailored to children and HCPs lack training on managing children. Treatment for survivors is generally similar for adults and children, however, the dynamics of dealing with children and adolescents and their needs are vastly different from adults [161]. A recently published case study found that healthcare providers in Kenya lacked the basic skills necessary to deliver quality services to minors such as obtaining informed consent, maintaining confidentiality, conducting a physical examination that maintains the dignity of the child and collecting specimens [163]. Our qualitative interviews found that none of the healthcare providers in these facilities had received any training on dealing with children and adolescents. The national guidelines for treating survivors are highly adult-oriented with a few sections dedicated to the management of children. There is an urgent

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need to develop treatment protocols specific for children and adolescents, and to provide appropriate training to healthcare providers.

Protocols for treatment of adolescents will need to address how to deal with young girls who are in consensual sexual relationships that are not socially and legally sanctioned as the girls have not reached the legal age of consent. This study indicated that more than 15% of the survivors at the hospitals fell in this category where parents disapprove of these relationships and therefore take the girls to hospital for treatment as sexual abuse. While this is clearly a legal issue, healthcare providers are faced with an ethics and rights dilemma as these survivors might be brought to hospital against their will and subjected to examination and treatment that they do not wish to receive. It is not clear whether bringing these girls to hospital and treating them as sexual violence cases actually stops the on-going relationships. More importantly, there are no guidelines for clinicians on what rationale or criteria they should use to make decisions on the type of treatment and additional support to offer.

It is also noteworthy that while Kenyan children frequently report sexual violence occurring in schools in national surveys such as the VACS, only a few of the children presenting at the hospital reported this. Child sexual violence in schools perpetrated by educators, peers and other school staff is common globally [164-166]. It is not clear why these children were heavily under-represented among the hospital respondents. Nevertheless, this points to schools being an important area for outreach- not only for primary prevention of sexual violence but also to get children who experience violence in schools accessing healthcare. Thus, creating linkages between schools and healthcare resources is crucial.

Limitations of the study

Gaps in documentation were a main challenge for the quantitative hospital data. These gaps were inevitable, given our use of routinely collected clinical data. To overcome this challenge, multiple sources of data were used to fill in missing data. We also conducted the study at two hospitals. While these two hospitals are not representative nationally, they provide a good overview and are likely to capture a more holistic picture of the

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survivors seeking treatment in Kenya than most previously-conducted research as they are both referral hospitals in two different counties.

Qualitative data were limited by the few HCPs interviewed and therefore theoretical saturation may not have been reached. However, these HCPs were purposely chosen to represent those routinely attending to sexual violence survivors, capturing the most significant experiences and an in-depth knowledge of the issues involved.

The VACS data excludes children below 13 years and the KDHS excludes children below 15 years, therefore, no comparisons for children below 15 years were made. Additionally, while the KDHS survey asks about violence perpetrated by both intimate and non-intimate partners, information on intimate partner violence is collected in more details and the findings should be viewed with this in mind. Overall, triangulation of national survey data, quantitative and qualitative hospital data enabled our data to be more comprehensive.

Conclusions

Our study finds that multiple barriers both at the hospital and community level result in missed treatment opportunities for survivors. Although national guidelines are available, the operationalisation of these guidelines at the hospital level is still limited by lack of staff training, poor coordination between service delivery points, lack of specific protocols for different categories of survivors as well as unavailability of basic equipment such as HIV kits, speculums and rape kits. This not only hinders provision of quality healthcare to survivors but also the collection of forensic specimen necessary for legal procedures. Specific clinical guidelines and protocols for treating children and adolescents are urgently needed

At the community level, older survivors; partnered or ever partnered survivors; survivors experiencing sexual violence from intimate partners; children experiencing violence in schools and men are at a higher risk of not accessing healthcare. Additionally, presenting late for treatment contributes to more survivors missing out on essential treatment.

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Interventions at the community level should reach out to those survivors who are unlikely to seek healthcare and address barriers to early access to care.

Chapter 6: Pathways of care for sexual violence survivors and survivors' perceptions of barriers to healthcare

6.1 Introduction

In chapter five, I identified missed treatment opportunities and groups of survivors who are likely to miss treatment. I also explored the barriers to comprehensive treatment through in-depth interviews with professional healthcare providers. In this chapter, I further explore these themes through examining the survivors' perspectives on treatment and barriers to seeking healthcare. The main aim of this part of the study was to get a deeper understanding of the survivors' healthcare seeking behaviours and their experiences both at the community and hospital levels. This was important to understand the survivors' actual experiences: factors that contributed to them seeking or not seeking healthcare, challenges experienced getting care, reasons for not completing treatment and views on the type of care they need. In so doing, I aimed to identify the challenges survivors face in the pathways of healthcare and potential areas where support interventions can be targeted to improve treatment seeking and completion.

Survivors were asked about their experience of healthcare seeking from when the violence occurred, if and when they went to the hospital, their experience at the hospital and subsequent follow up. Survivors also described their experience disclosing the violence, to whom they chose to disclose to, how disclosure influenced their health-seeking decisions and for those who had not disclosed, the reasons for not disclosing. They were also asked about their experience seeking services other than healthcare such as legal and justice. The chapter starts with a description of the methodology specific to survivors followed by the findings on survivor experiences seeking healthcare. Survivor experiences with CHWs are described in chapter 7.

6.2 Methods

In this section, I describe the selection of the participants, the data collection process and ethical issues specific to survivors of sexual violence. The overall detailed study methods are described in the methodology chapter (chapter 3).

6.2.1 Sampling

In order to collect information that might show variations in survivors' needs for appropriate healthcare as well as differences in issues such as ethics of follow-up, stigma and reporting patterns, the study sampling was done with an aim to maximise the diversity of survivors interviewed. This enabled the study to explore which types of survivors might have more trouble accessing services and whether CHWs might be able to help them more or conversely which survivors might actually not be able to make very good use of CHWs and might be missed by CHWs. Therefore, sexual violence survivors followed up either at the facility level and/or through CHWs were selected in order to explore views from those who use and those who do not use CHWs services. Additionally, I made efforts to identify survivors who did not seek healthcare. This was important to collect views of these survivors on reasons why they did not seek healthcare and views on whether CHWs services would have made accessing services more amenable to them.

6.2.2 Selection of participants

I aimed to sample different categories of survivors including: 1) survivors who had accessed hospital services and were at different stages of care (from just starting to having completed treatment); 2) survivors who had not accessed hospital services; 3) survivors who had used CHWs services; and, 4) survivors who had not used CHWs services. To increase the likelihood of sampling survivors from each of the above categories, I selected survivors using two methods. The first was identifying survivors accessing services at the hospital level using the nurse counsellors and the second identifying survivors who had not accessed hospital services through a CHW working with the WKF.

Inclusion: Survivors were included if they were 18 years and above. However, I also planned to include emancipated minors. According to the HIV and AIDS Prevention and Control Act (ACT NO. 14 of 2006), in Kenya, emancipated minors are defined as below 18 years and married, pregnant or already parents. I planned to include this group in consideration of the fact that previous data suggested that nearly 50% of survivors of sexual violence treated in Kenya are children [3, 5, 8, 67, 92]. Despite the plan to include

emancipated minors, none were recruited because they are a hard to reach group. For the same reason, I was not able to recruit male survivors for interview.

6.2.3 Recruitment of participants

The recruitment team comprised of two nurse counsellors (one from each hospital) and one CHW. The nurse counsellors were a crucial component of the hospital's services for survivors and were the contact persons for any issues relating to SGBV. They were both trained trauma counsellors. The CHW had training in SGBV and worked as a community mobiliser and organised support groups for survivors. At the beginning of the exercise, I conducted informal training with each of them. The training lasted between 1-3 hours and comprised of: an introduction to the study and study objectives; participants' eligibility; ethical issues such as confidentiality and voluntary participation; and, the recruitment procedure. The informal training was deemed sufficient as all three were already dealing with survivors and their role was limited to contacting and recruiting survivors only.

At the hospital, we (the nurse counsellor and I) used the SGBV register to identify survivors who were at different levels of care. We identified survivors who had just started treatment, survivors who were nearly completing treatment and survivors who had already completed treatment. In addition, we identified survivors who had records of initiating treatment but had no records of follow-up. The SGBV register documents the contact details of each survivor and we extracted this alongside other details such as the age of survivor, when first treated and follow-up visits.

The nurse counsellor then contacted each survivor. I felt that the nurse counsellor was the most suitable to do this as she had previous contact with the survivors and therefore building rapport over the phone would be much easier for her. We discussed the 'script' she was to use when contacting the survivors. Firstly, she was to ascertain she was speaking to the survivor, and then identify herself and where she was calling from. She would then enquire if the survivor was in a position to talk or if she would prefer to be called later. Once the survivor gave permission to proceed, she informed them that there

was a researcher based at the hospital who was conducting research on healthcare services and who would wish to interview the survivor. She emphasised that the research was an independent piece of work that did not affect their healthcare in any way. If the survivor agreed, they were then asked for a date and time that would be convenient for them to come to the hospital. The nurse counsellor also identified survivors attending hospital appointments and requested their participation. On the scheduled date, the nurse counsellor received the survivors and escorted them to the interview room where she introduced us and then left the room. I then went through the study information sheet and the consent form with the survivor. If after providing the information the survivor consented to participate, we then discussed whether they were able to do the interview immediately or wanted to schedule a different date. Only one survivor requested to postpone the interview while all the others agreed to proceed on the same day.

Similar to the nurse counsellor, we went through what the CHW was to tell the potential participants and how to refer them to me. The CHW was to approach the survivor, tell the survivor that I was doing research on health-related issues and was interested in talking to them. If they agreed to talk to me, the CHW then asked them for a convenient date, time and place to meet me. Once we met, I went through the same procedure as with the survivors recruited from the hospital.

In total, 28 survivors were identified by the nurse counsellors. Three of these survivors could not be reached on phone. Of the 25 who were contacted; two were unavailable for interview (one was sick and the other busy); two had moved out of the area; and five agreed to the interview but did not turn up on the interview date. The remaining 16 survivors were successively interviewed. Eight survivors were recruited by the CHW and were all included in the study.

6.2.4 Data collection

I conducted in-depth interviews (IDIs) with 24 sexual violence survivors using open-ended IDI questions (Appendix 2-3). In-depth interviews were chosen as they are noted to offer

a better avenue to investigate “deep rooted or delicate phenomena”, in this case a highly stigmatised condition, compared to other methods [167]. Interviews were conducted in English and where a participant was not comfortable with English, Swahili, the Kenyan national language, was used. I am fluent in both English and Swahili. The IDI guides, consent and information sheet were translated to Swahili. Participants who could not totally communicate in either English or Swahili were excluded.

Due to the sensitivity of the topic, I expected that survivors may be uneasy on our first meeting and I therefore planned to conduct up to two subsequent interviews with some. The first interview would be introductory and aimed at creating rapport and then follow that with a second more in-depth one at a later date for those survivors that I felt did not open up fully during the first interview. This however did not happen as I was able to establish good communication with all the survivors during the first meeting. One follow up interview was conducted with a survivor who was just starting treatment to explore her experience through the treatment process.

6.2.5 Ethical issues

Discussing the experience of sexual violence may have adverse psychological and emotional effects on the survivors. A few participants experienced mild emotional distress during the interview. When this happened, the interview was stopped and the participant given sometime to compose themselves. I have previous experience working as a medical doctor and as a researcher interviewing survivors of gender-based violence, patients with other sensitive conditions such as HIV and children. Moreover, I also worked in a mental health facility where I conducted multiple mental health assessments and counselled several patients. This past experience helped me to identify participants with any distress or psychological difficulties and take necessary action including referral to support services. None of the participants experienced severe distress during the interviews to warrant discontinuing the interview completely. However, two survivors were judged to need further psychological support and were referred to the psychological counsellor at the hospital. All the other survivors were offered referral to a counsellor but none took up the referral.

Other ethical issues including consent, confidentiality, privacy and anonymity are detailed in the methodology chapter section 3.7.

6.3 Findings

Firstly, the socio-demographic characteristics of survivors interviewed are presented. Secondly, survivors' experiences prior to accessing healthcare are described. These include circumstances around the sexual violence and the perpetrators; experiences around informal disclosure (to friends, neighbours and family members); formal disclosure (to healthcare, legal and justice service providers); the reasons for and against disclosure as well as people disclosed to and responses to disclosure. Thirdly, experiences through the process of accessing healthcare are outlined. Survivors' experiences within hospitals are then discussed including within hospital pathways, views on services received and barriers within the health facilities. This is followed by presentation of findings on follow up, community support and survivors' views of additional services needed. Finally, discussion on the findings and the study limitations are presented.

6.3.1 Socio-demographic characteristics of survivors interviewed

The characteristics of survivors interviewed are presented in table 6.1. Those interviewed were all female. The youngest survivor was 18 and the oldest 43 years, with a mean age of 29 years. The majority, 12 (50%) were single, seven (29%) were married, three (13%) separated and two (8%) widowed. Three (13%) had a college or university education, eleven (46%) secondary, nine (37%) primary and only one (4%) with no formal education. In terms of employment, half 12 (50%) were either unemployed, domestic workers or had some other casual jobs.

The survivors experienced violence at different time points in their life, ranging from one week to 14 years, with the majority having experienced violence in the past year. All the survivors had experienced at least one rape. Among them: one reported experiencing rape and female genital mutilation at the same time; one reported rape and sodomy; six

(25%) reported being assaulted by 2-4 perpetrators at the same time; ten (42%) reported the perpetrators were known to them; and, two reported experiencing more than one incidence of rape in their lifetime starting from childhood. Seven (29%) had completed HIV PEP treatment, four (17%) started treatment but never completed, six (25%) were continuing with treatment and seven (29%) did not seek healthcare after the violence. Among those who had not sought healthcare, four reported getting pregnant and bearing a child from the rape and one reported contracting syphilis and HIV.

Table 6.1: Characteristics of interviewed sexual violence survivors

Characteristic		Frequency (n=24)
Age	Mean (range)	29 (18-43)
HIV PEP treatment	On HIV PEP	6
	Completed HIV PEP treatment	7
	Started HIV PEP but didn't complete	4
	Never started HIV PEP	7
Time since sexual violence	1 month post violence	6
	2 -6 months post violence	7
	7-12 months post violence	4
	More than one year post-violence	7
Marital status	Single	12
	Married	7
	Separated/divorced/widowed	5
Education	None	1
	Primary	9
	Secondary	11
	Post-secondary	3
Employment status	Unemployed	4
	Student	1
	Domestic worker /casual worker	9
	Self-employed	6
	Formal employment (teacher, sales, engineer)	4
Type of perpetrator	Known	10
	Unknown	13
	Both known & unknown	1
Number of perpetrators	1	18
	2 or more	6
Number of times ever experienced sexual violence	1	22
	2 or more	2

Abbreviations: HIV- Human Immunodeficiency Virus; PEP- Post Exposure Prophylaxis

6.3.2 Circumstances and perpetrators of violence

The findings indicate that violence happened most commonly in familiar places; was perpetrated by both known and unknown persons; and, economic vulnerability played a significant role in the experience of violence. Violence happened mostly to survivors in

their own home or on their way to and from home. Only three survivors reported being taken by the perpetrator to places they had never been before, with one reporting being driven nearly 100km away. Perpetrators used various methods to target the survivors, for instance tricking survivors to accompany them, attacking survivors walking at night in deserted places, offering lifts and breaking into homes. Trusted persons such as friends and people known to the survivor or their family also carried out attacks at home. In nearly all the instances, force including being strangled, suffocated and being threatened with a weapon was used. Re-victimisation was reported with two survivors describing multiple incidents of violence beginning from childhood.

One survivor who had experienced three incidences of sexual violence captured the breadth of circumstances under which violence occurred from childhood when she described her situation,

“Some things happened in our family and my mom and dad separated when we were very young. My dad married another woman, and then moved from where we were living to town. Then we were left alone, and therefore the extended family members had to take up the responsibility of taking care of us. My aunt’s daughter took me, so that I can assist her in taking care of her child. Her brother-in-law called [name of perpetrator] - he was huge in size. While my cousin was away, he used to take me to some other building that was coming up nearby, where he used to rape me [...]. Then I went back home and I stayed at home for a while; life became so difficult which prompted me to run away to go search for a house help job. As I was doing the house help job, there used to be a neighbour. I used to be paid 300 shillings, and the man used to give me 100 shillings as way of helping me but in exchange for sex. At that time, I was not even seventeen years [...]. After that, I came to Nairobi to live with my brother. I then got a casual job at the airport [...]. At around 5:00am [while on the way to work], I met guys near the fence of a school called [name of school] who raped me. They were two [...]. When the first guy pointed a pistol at me and warned against screaming and I had not experienced anything like that before, I was shocked and fainted.” (Survivor, WSV01)

In her description, she reiterates what other survivors reported namely: that perpetrators were both known and unknown, violence happened mostly in familiar places and threats of harm were common. Economic vulnerability appeared to play a role in the experience of violence. Similar to the above scenario, many of the survivors were attacked while

leaving either too early in the morning to work or late at night from work. Others were attacked at their place of work such as a pub and some survivors reported being tricked to accompany a person to a potential job only for that person to sexually assault them in a building or deserted place.

6.3.3 Experiences with informal disclosure of sexual violence

Disclosure was not an easy thing for many survivors. Most survivors did not disclose the incidence of violence to anyone. Even among those who disclosed, only a few did so immediately after the violence happened. For some survivors, disclosure occurred much later, and for some, even many years later. Overall, having a trusted person was key to informal disclosure; informal disclosure led to healthcare seeking; and, social stigma was a significant barrier to informal disclosure.

6.3.3.1 People disclosed to

Those survivors who chose to disclose spoke to a variety of people who were close to them including friends, siblings, mothers and husbands. Nearly all the survivors disclosed to people who were well known and trusted by them. One survivor however did talk to strangers when she felt she had to talk to someone but did not want to disclose to those close to her for fear of negative reactions and changes in relationships. There were different levels of difficulties in disclosing, and these varied depending on to whom the survivor was disclosing. Disclosing to a close friend was relatively easy. Many survivors said they had that one friend with whom they shared everything, so they had found it relatively easy to talk to that person.

“A cousin of mine who previously went through the same rape ordeal, so in the morning when I woke up she was the first person I called. I told her what happened, the rape and she encouraged me to go to the police then the hospital [...] she is the one I share my secrets with.” (Survivor, TSV01)

Even among family, disclosure tended to be to a close and trusted family member rather than the whole family. Disclosing to a spouse was particularly difficult. Fear of being blamed and abandonment played an important role in survivor’s decision not to disclose to a spouse.

“I have not told him. It is hard for me to tell him, how will I start telling him? [...] He might chase me and tell me to leave or he might leave me. There are many things he might think [...]. He might think you wanted it, you went out and met with someone who did that to you. He might think you are not faithful, you have an affair he doesn't know about then you will bring diseases to him. You see there is nothing a man cannot tell you.” (Survivor, NSV11)

For some survivors, disclosure was often a process rather than a one-off event. To protect themselves, survivors prioritised what to disclose, how much and when. One survivor for instance described how she had taken time to build a trusting relationship with a CHW after which she only disclosed her abuse as a child and was yet to disclose that she had experienced sexual violence as an adult too.

“The way I came to know her [a CHW], there is a day she was mobilising community at a training. Then a friend of mine invited me to go and get some training. I just sat behind. After training, I followed her – I am the one who followed her. I spoke with her since she had spoken about key points that, no one should know the other person's secret [...]. I only told her the incidences when I was a child but not the one when I was a grown up, because that was the moment when we were building a relationship [...]. We have been close but I only told her the details that were disturbing and hard to keep to myself.” (Survivor, WSV01)

For a few survivors, disclosure also occurred without the survivor volunteering the information. Instead, other people who knew about the violence disclosed to third parties, some close to the survivor and some not. The effect of this type of disclosure on the survivor varied, in some instances being helpful and in some others not. One survivor reported that she had been assisted with advice and money to go to the hospital by strangers who heard about her plight from other people. A second survivor reported that she disclosed to a close friend who then helped her disclose to her family, and this made it easier for her. A third survivor however reported that this type of disclosure had created an awkward atmosphere in her family. Although she knew her family members (two brothers and her mother) had been informed about the violence, they never talked about it with her. This survivor indicated that one of her brothers is a professional healthcare provider who was assisting her get treatment and yet he had never discussed the issue with her. She explained that although she would not wish to talk to them about

the violence, the fact that they knew but had said nothing to her made her feel like they are not concerned about her.

“Actually I have never talked to any of them about it [...] and I wouldn’t agree to talk about it. For some reason I feel more comfortable, though to some extent it also feels like they don’t even care. So I don’t know, maybe they just read my mind or they just don’t care, so I don’t know for sure.” (Survivor, NSV02)

Overall, data suggests a potential link between informal disclosure and healthcare seeking. All the survivors who disclosed informally sought healthcare while the majority of those who did not disclose informally did not seek healthcare. Many of those who disclosed informally reported that those disclosed to influenced their healthcare seeking. A few survivors chose not to disclose informally but sought formal healthcare. The reasons why survivors chose to disclose informally or not to, as well as how those disclosed to influenced their subsequent behaviour are described below.

6.3.3.2 Barriers to informal disclosure

Themes emerging around the reasons for not disclosing included fear of being blamed; shame and fear of stigma; loss of social and economic safety; and, a feeling of hopelessness.

Fear of being blamed for the sexual violence: Generally, survivors were viewed as being partly or fully responsible for the violence happening to them. Blame could be associated with having done something contrary to what was expected or going against previously given advice to avoid exposure to potential violence. For instance, some survivors indicated that their spouses had warned them against accepting lifts from strangers, coming home late or passing through a certain route. Therefore, when violence happened in those settings, they chose not to disclose for fear of being blamed.

“I was unable [to tell her husband], there is a time I took a lift and the man tried to rape me. So that time I told him. Because then I was in a trouser, the man was not able to rape me. This time, I was in a dress and that is why they [two men] were able to rape me. That first time I told my husband I took a lift and a man tried to rape me and he told me never to take a lift again [...] so since he had forbidden me from taking lifts I couldn’t tell him because he would say I wanted.” (Survivor, NSV07)

The suggestion by this survivor that the way she was dressed somehow contributed to the sexual violence also illustrates a commonly expressed rape myth that the way of dressing provoked the perpetrator to commit the violence. In addition, blame was apportioned to survivors who invited perpetrators to their house, were alone with a perpetrator when the violence happened or previously had any association with the perpetrator. Under these circumstances, survivors felt that they would not be believed if they disclosed the violence.

“It’s not worth talking to them [other people], how will they see me, you know people have different views of thinking, they will think it was just but a lie or maybe I wanted it. Furthermore why did I invite that person there [to her house at night], so am like let me keep it to myself.” (Survivor, NSV04)

“They have been saying perhaps you wanted it, or you were used to receiving money from the perpetrator that is why he did that [raped her], or maybe you were interested in him/was after him, such things.” (Survivor, NSV11)

Being drunk or involved in work that was perceived to be disreputable such as selling alcohol was another avenue survivors were thought to have brought violence upon themselves. Similarly, they could be blamed for their “carelessness” for instance if they were walking at night or did not secure their house well enough. The fear of being blamed not only hindered disclosure but also healthcare seeking. Some survivors feared that healthcare providers would blame them too.

“Even my people I was fearing [to tell them] because, something like that, many people think if you are selling alcohol you are also selling yourself so not many would agree [that you were raped]. So I just stayed, I didn’t even go to the hospital. I didn’t go because I was wondering even how to start telling the doctor because there are other harsh ones you go and start and they tell you, “you are the one who took yourself, don’t you sell alcohol” you see, things like that.” (Survivor, WSV04)

“In most places people actually blame you. The first question is why were you there? Why wouldn’t you have come earlier, or why wouldn’t you have come tomorrow, or why did you use that route? But the truth is you never know what

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happens, coz for me I was just walking at night. Since I was small, my dad is a night traveller most of the time so I was used to travelling at night and it is almost kind of fun, you sleep, no worries [...]. There was a time I was working in Narok, I used to come at night and get at home maybe at eleven and I was fine. So you know it is not fair blaming me and it is something I've been doing and nothing has ever happened.” (Survivor, NSV02)

Shame and fear of stigma: Shame and fear of stigma played a major role in the decision of not disclosing. Not being sure how to disclose, who to trust and how those disclosed to would react were common reasons for not disclosing. Nearly all the survivors who did not disclose said they did not do so as they were worried about peoples' reaction towards them after disclosure. They worried about how people “would take it” and how they would view and treat them after that. Survivors therefore feared disclosing as they felt the person disclosed to would tell someone else and ultimately everyone in the community would know.

“You know that act, you look like you are not telling the truth. Again, you think if you tell someone, they will be scornful and think you are not a good person. So I decided, let me keep my problems to myself because I might tell someone and then it becomes like a story, they will tell everyone. So everyone will take me like I am not important in the community [...] they won't accept you.” (Survivor, WSV08)

This fear of spread within the community was particularly distressing for women who had families and children as none of them felt comfortable with their children getting to know about the violence. As the above survivor illustrates, there was the perception that survivors are not appreciated, respected or treated as equal members of the community. Often, survivors faced discrimination and isolation in the community. The association between HIV and rape that was prominent in the community compounded the shame and stigma of sexual violence. Community members assumed you automatically acquired HIV when raped. Due to the notion that rape was associated with HIV infection, survivors failed to disclose to avoid being labelled HIV positive and thus subjected to the same stigma as those infected with HIV.

“They start talking about you, it is like they isolate you, they gossip about you all the time, so and so got sick [HIV], you know that disease, when one gets it, it seems like you will die tomorrow, so people just fear it.” (Survivor, NSV03)

“People think once you are raped you are sick [...] you have HIV [...] in fact when you are raped they think AIDS, straight away, you have HIV. Now it is not even syphilis or those other funny diseases, they automatically think you now have AIDS.” (Survivor, WSV07)

This fear and stigma of HIV was deeply embedded in the community and was closely linked to religion and notions of morality. Thus, people who were HIV-infected were viewed as being less morally upright or having done something that deserved being punished by God as this survivor expounds:

“People there [her home village] don’t like talking about HIV and issues such as this [rape]. In fact, if they know you have been talking about such things, they won’t even visit your home. I don’t know how they take it, there is a time I went with another organisation to teach in a church, they were shocked they could not talk. You ask them questions they won’t answer, they were saying it is a curse, if you see someone like that [infected with HIV] that is a person who has been cursed by God, that person has made God angry and has been cursed as a result, he/she has bad manners.” (Survivor, WSV05)

Loss of social and economic safety: A few survivors reported fearing losing their social and economic support as a result of disclosing. They feared that they would no longer hold the same position in the community once they disclosed that they had been sexually violated. This was closely linked to the earlier observation that survivors lost respect, acceptance and value both at the family and community level. Thus, survivors lost the social safety that comes with being accepted and belonging to the community by disclosing. For young unmarried survivors, this was manifested in fear of losing the potential to attract a future partner if the community knew about the violence.

“And then I could feel it is a shameful thing. So I was forced to just persevere and by then I was just a young girl and I was not married, till I felt like I would never be married in my life.” (Survivor, WSV01)

For married survivors, fear of how the spouse would react including the possibility of being abandoned hindered disclosure. The fear of what a spouse may do was sometimes so overwhelming it overshadowed guilt feelings of exposing a spouse to potential harm.

This is well illustrated by a survivor who found it difficult to disclose even after she developed complications including conceiving and being infected with both syphilis and HIV:

“So, when I went back home, I couldn’t even sit because of pain. And when my husband came, he wanted his rights [meaning sex] so I lied to him I was on my monthly period [...] so I kept buying medicines, painkillers till the pain was over. But then after a month I realised I had not received my monthly period so I went and had a pregnancy test and I was pregnant. And I was sure my husband was not responsible for this pregnancy. I could count my days, those were the days I had been away in the village [where she was raped], so I was not sure what to do, what to say or if I should abort. I decided not to tell anyone, I kept quiet. So it reached a point we started having sex with my husband so that if he ever asks me about the pregnancy, I would say it was his [...]. I started getting unwell because of the pregnancy, I started going for antenatal clinic at four months. They had to do some tests; I was tested and found to have syphilis and HIV. I was asked to go with my husband to be tested but he refused as he was a drunkard [...]. So I was put on antiretrovirals which I continued taking. My husband died in 2013 but he did not know the child was not his.” (Survivor, WSV05)

This survivor explained that although her failure to disclose and her apparent deception weighed down on her, she was afraid to tell her husband as she suspected he would abandon her after that. Despite the fact that she did not know her HIV status prior to the violence, never knew her husband’s status as he died of unrelated causes without ever being tested, she concluded she was infected during the rape. Her situation mirrors the already mentioned tendency in the community that a survivor would automatically be labelled as having acquired HIV from sexual violence, and therefore will be blamed and stigmatised.

Feeling of hopelessness: Another reason repeatedly given for not disclosing violence was the view that disclosing was useless and added no value to either the survivor or the person being disclosed to. Phrases such as “what good is it”, “what will they do if I tell them”, “they can’t reverse it” were commonly used. Disclosing was therefore viewed as adding to survivors’ problems rather than helping them deal with it. One young survivor aptly summarised this ‘uselessness’ of talking to any one thus:

“Apart from the fact that they might change the way they look at you and everything, I always feel more comfortable when my troubles are with me, you know. I don’t have to go talking to everyone this happened [...]. Telling them will not help me in any way [...]. The fact is, it’s not like if I don’t have school fees, if I don’t have school fees, some of them might offer to pay for my school fees. But if I were raped, no one would do anything to help me. No one is going to offer money. And money is not going to change the situation.” (Survivor, NSV02)

6.3.3.3 Reactions by those disclosed to informally

Actual experiences of survivors with informal disclosure varied and revolved around disclosure having been helpful; disclosure being met with pity/helplessness or indifference; disclosure being met with anger either towards perpetrator or survivor; and experiencing more psychological trauma as a result of disclosure.

Helpful support: Disclosure was found to be useful for most and survivors reported a variety of support they received from the people they talked to. Advice to seek healthcare services; encouragement and support through the process of seeking healthcare and justice; and, financial support were some of the things survivors received. Some survivors reported that disclosing was the only reason they sought healthcare.

“At first I didn’t think of coming to the hospital, actually the guy advised me to come, he brought me here.” (Survivor, NSV04)

As with this survivor, persons disclosed to either wholly took the responsibility of taking the survivor to the hospital or accompanied the survivor, providing psychosocial support through the process. It was notable that regardless of the level of support received, all the survivors who disclosed informally also sought healthcare. This is possibly a reflection that the support received helped survivors seek healthcare (as some reported) or those who disclosed were less vulnerable to the other barriers of healthcare seeking such as stigma.

For others, disclosure was met with pity, helplessness or indifference: In spite of the help received, those disclosed to exhibited various other reactions that were not always comfortable to survivors. These included pity, helplessness, shock and other forms of emotional disturbance. Being indifferent and attempts by those disclosed to, to try to lighten the gravity of the violence by comparing it to ‘everyday’ occurrences was

distressing to some survivors. One survivor described how her relationship with her sister deteriorated because when she told her she was raped, the sister told her that being raped is “like being in a car accident.” The survivor felt her sister had not taken her problem with the seriousness it deserved. Being an object of pity and also the idea that a survivor may cause distress to the person they disclose to were a source of discomfort as demonstrated by this survivor,

“If you tell someone that maybe somebody was raped, people get shocked, then I did not want to be pitied so much, because you can tell somebody they start crying.” (Survivor, NSV08)

Some therefore failed to disclose to avoid putting pressure on other people and to protect other people’s feelings, particularly parents.

Disclosure being met with anger: There was also a tendency for those persons survivors disclosed to, to initially be annoyed and bitter at either the survivor or the perpetrator. The bitterness displayed towards the survivors was primarily because the person blamed the survivor for letting the violence happen. There was the tendency to rationalise that if the survivor had not behaved in a certain way, they would not have experienced the violence.

“He [husband] was upset because I stayed out late and instead if I came home before it was dark I wouldn’t have experienced it.” (Survivor, NSV13)

6.3.3.4 Factors supporting informal disclosure

Various factors contributed to survivors disclosing: having someone trustworthy; fear of infections; as way of dealing with psychological trauma; and, coming across someone dealing with a similar issue.

Having someone trustworthy: Having someone they could trust was an important factor for all the survivors who disclosed. The person disclosed to determined who else in the community got to know. Thus, disclosure to the wrong person would lead to the ‘whole’ community knowing and a survivor experiencing the resultant stigma.

Fear of STIs and HIV infection: Although the fear of the stigma of HIV was a strong barrier to disclosure, for a few survivors, fear of getting infected with HIV and other STIs was a driver to disclose particularly to a spouse. Thus survivors feared that if they got infected

with HIV during the rape, they might also infect the spouse. It was therefore important to reveal the violence early so that they would be believed in case of such an eventuality.

“What influenced me to tell him [husband], it’s because I thought if I keep it to myself and maybe that person was sick [meaning HIV infected] and then my husband and I get sick and he knows that himself he is loyal [meaning does not have other sexual partners] then he will think that am not loyal. In case of anything then he will be in a position to know what happened.” (Survivor, NSV13)

For this survivor, the fear of infecting her spouse coupled with a desire to maintain her trust with him drove her to disclose.

A way of dealing with psychological trauma: A few of those who did not disclose immediately eventually did talk to someone over time, some many years later as a result of psychological suffering and realising they could not deal with what they were going through alone.

“I told my friend because it [rape] traumatised me. It pained me so much I couldn’t hide, there are things you can hide but they disturb you so much you have to talk it out one day- and she was a very close friend.” (Survivor, WSV07)

The need to deal with psychological trauma was sometimes so strong it led one survivor to talk to complete strangers when she felt she needed to talk to someone but did not trust those close to her. She explained that talking to a stranger was preferable to talking to someone who they will be in regular contact with, and, that she found talking to these strangers helpful as they gave her advice on what to do.

“Like there is somebody I talked to yesterday [about the violence] and another one I have told today. That person I know, we will never meet again. But someone from where I come from, we will continue meeting [...]. It has helped me [talking to the strangers], they advised me to look for the human rights offices I talk to them.” (Survivor, NSV05)

6.3.4 Formal disclosure

6.3.4.1 Disclosure to healthcare providers

All the survivors who disclosed informally, and a few of those who did not, disclosed to medical personnel. Data showed survivors had mixed feelings with regards to disclosing violence to HCPs. While most survivors were comfortable talking to HCPs, some were not.

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A few survivors reported they initially had doubts about going to the hospital because they feared the HCPs. Although for some it was fear related to talking about sexual violence and whether the HCP would believe them or not, for others it was a general fear of hospitals based on either past experiences or what they had heard in the community.

“To be honest I have always been scared about hospitals. I hate hospitals actually. So for one when I had to come to the hospital I was not exactly thrilled. One of the things that people are scared about is, I have to tell them what happened, it is not exactly a good experience. But they are so motherly, I can say that. So you don’t have to be worried about anything, they don’t shout at you like I hear most people saying nurses are not friendly, especially lady ones, but these ones are.” (Survivor, NSV02)

Survivors going to the hospital in the weeks following violence for symptoms related to the violence and not disclosing to the HCP attending to them was common. More than half of the women who did not seek specific healthcare for sexual violence visited a hospital in the days or weeks following the violence but chose not to disclose to HCPs. They therefore received treatment for symptoms they were experiencing such as vaginal discharge but not for sexual violence per se. As this survivor explained, shame was the main reason why they failed to disclose:

Survivor: *I was not found to have any diseases but I was pregnant. Those 3 weeks, I was feeling unwell but I did not know how to tell anyone.*

Interviewer: *When you found out you were pregnant, did you tell them at the hospital how you got pregnant?*

Survivor: *You know, I did not bother to tell them, because, I was feeling ashamed of myself. (Survivor, WSV02)*

This observation that some survivors did go to hospital but chose not to disclose violence is particularly important as it highlights opportunities that survivors could have received necessary treatment but failed to. Failing to declare sexual violence could lead to misdiagnosis and wrong treatment. For instance, one survivor who reported getting pregnant and contracting STIs after sexual violence presented in a hospital two days after the violence when both HIV PEP, treatment for STIs and emergency contraceptive could have been issued. However, this survivor did not disclose the violence to the doctor and

was instead treated as a case of malaria. All the three other survivors who got pregnant visited a hospital in the month following the violence but never disclosed their violence, and also did not disclose throughout their antenatal care and delivery.

6.3.4.2 Reporting to the police

Disclosure to the police was limited with less than half of the survivors reporting to the police. It was notable that all the survivors who did not seek healthcare also did not report to the police. However, there was no indication that going to the hospital played a significant role in the decision to report to the police as only one survivor was referred to the police from the hospital: all the others reported to the police before going to the hospital. Survivors gave various reasons for not reporting to the police. The majority failed to report because they did not know the perpetrator and did not think the police would do anything about it. Others did not get encouragement from those they disclosed to while for some, because of normalisation of sexual violence in the community, they did not consider it a big issue worth reporting.

“Now, even if I went to the police, who would I say it is and I don’t know them [assaulted by four men]? You know, you report something when you know it is so and so. Now, even if they asked me who it was, I would not know who they were.” (Survivor, WSV02)

It was evident from survivors who reported to the police that there was lack of clarity about when it is appropriate to report to the police with most attaching more urgency to reporting to the police than seeking medical attention. A few survivors felt that getting a police referral was a prerequisite to getting medical care. This lack of clarity resulted in delays in seeking healthcare.

“I followed the rules that one should follow when something like that [rape] happens. When you get something like that, first you need to report to the police station nearest to you. Before you report to the police, you should not do anything, you shouldn’t bath, you shouldn’t change your clothes, you shouldn’t change anything and you go report. After reporting, there is a letter the police will give you to bring to the hospital. That letter is the one you give to the doctor, you tell them what has happened and then they will assist you.” (Survivor, NSV11)

This illustrates a need for survivor education on what to do as delays in seeking medical care may compromise treatment.

All the survivors who reported to the police failed to follow up their cases. In most instances, perpetrators including those who were known disappeared and could not be traced. As such, reporting was deemed not useful as perpetrators were rarely apprehended. Among those who reported to the police, none reported pursuing the case further with the legal and justice system, many citing bad experiences with the police as the reason. The police were found to be insensitive and unhelpful. Some said the police did not believe them, accused them of not doing enough to prevent the rape or colluded with perpetrators to intimidate the survivor.

“I was to go for the P3 [police medical examination report form] and have it filled here [hospital] then I take it back to the police station but they have really disturbed me. They say I didn’t scream, they say they can’t get evidence [...]. They ask me I didn’t scream, how come I was raped and still went back into that car [...]. Since my pantie or trouser were not torn, that it is possible we had agreed.” (Survivor, NSV05)

Lack of confidence in the ability of the police to arrest unidentified perpetrators also contributed to survivors giving up on the cases. There was the perception that the police were uninterested or incapable of pursuing a perpetrator based on a survivor’s description only. This is in line with those survivors who did not report to the police in the first instance because they did not know the perpetrator and did not think the police would do anything about it.

“As always it is not that easy, because you have to answer, why are you here? This happened- where, why, why were you walking at night? [...]. And the police are not exactly fun to talk to, some of them are quite harsh [...]. I only went there to pick my P3 [...]. We are in Kenya to start with. And considering the fact that I only recognised the jacket and the shabby look, nothing apart from that and the tallness, he was quite tall. Naturally, Kenyan police wouldn’t use that to go after a guy. They just relax and wait for you to find him.” (Survivor, NSV02)

6.3.5 Experience of accessing healthcare

The way survivors’ reacted to the incidence of violence varied between survivors and was dependent on circumstances surrounding the incidence such as where it happened, when

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and who the perpetrator was and the advice given by those around. Immediate withdrawal from other people for hours and even days appeared to be the most common initial reaction that survivors had. As the survivors explained, this allowed them time to think and make a decision on what to do. A decision to either keep the incidence to themselves, to seek services on their own or to talk to a friend or family member was then made. The time taken to make this decision varied from a few hours to days.

More than two thirds of the survivors interviewed went to the hospital after the violence or a few days later due to symptoms related to the violence. The majority of the survivors, including those that did not go to the hospital, thought that they needed to seek healthcare services. Survivors had learnt of the importance of seeking healthcare through various routes including having been taught at school and awareness talks given in churches and community groups. Those who went did so to avoid pregnancy and contracting diseases, particularly HIV. Even among those who went for healthcare, many did not go to the hospital immediately. Personal circumstances often dictated the course of action and sometimes overshadowed the need for immediate healthcare, even when survivors recognised that need. Survivors who were assaulted at night for instance waited until the next day to seek healthcare. While such delay may be inevitable, it may compromise treatment and collection of forensic specimen. Survivors often bathed and changed clothes during this period thus losing some crucial evidence.

Witnesses to the violence and those people that survivors disclosed to played a crucial role in determining when the survivor went to seek healthcare. This observation was a clear indicator of the importance of education and awareness creation among community members on the need for survivors to seek immediate healthcare. Once other people became involved either through disclosure or having witnessed the violence, they became almost as crucial as the survivor in determining what the survivors' next course of action would be. Some of the survivors reported that they only went to seek healthcare as a result of the advice given or action taken by others.

“May be if you tell someone like the way I did telling my friend this and this has happened, he took that responsibility of taking me to the hospital, I had said that I won't go but at least he took that responsibility of taking me.” (Survivor, NSV04)

However, this prompt action by others to get the survivors to hospital was not universal. In some cases, advice given to survivors contributed to substantial delays in seeking healthcare. A survivor who was drugged and raped in her house by robbers reported that the estate caretaker, who discovered her unconscious in her house in the morning, advised her to first go report to the police. After reporting, the survivor then had to accompany the police back to her house for the police to inspect the crime scene. Only after the police had completed the inspection did they advise her to go to the hospital. In this instance, the importance attached to reporting to the police first, coupled with the fact that the police asked the survivor to accompany them back to her house resulted in the survivor delaying healthcare substantially, and possibly experiencing revictimisation through revisiting the scene and retelling her story. It also points to lack of information and misinformation even among formal services such as the police.

Other survivors reported that they didn't go to the hospital immediately because they were 'confused', feeling "unreal", were not sure of what to do or they felt "worthless". In addition, attending to the usual responsibilities such as taking care of the family and reporting to work commonly hindered immediate seeking of healthcare. This is a pointer that having knowledge of "what to do" alone does not guarantee the right course of action: the environment and social circumstances also play a significant role. One survivor explained that even though she knew she should ideally go to the hospital immediately and not take a shower, it took her more than 20 hours to get there as she had to first take care of her children that night and report to work the next morning:

"To me you know that after something like that [rape], I am a teacher, we should go to the nearest health centre, hospital within 72 hours. So when it happened, okay, I had to report to work first then I came here in the evening hours. That is why they [doctors] were asking me, when did it happen. I told them it was last night. And you see you cannot go to work when you have not taken a shower. So I took a shower, went to work and then I came." (Survivor, NSV12)

6.3.6 Hospital process, services and challenges

Generally, survivors perceived the services received to be satisfactory. However, the hospital process was tedious and complicated with multiple challenges including lack of informed consent, long waiting duration, multiple service delivery points and poor staff attitudes.

6.3.6.1 Process and services offered

Survivors mostly went to the hospital unaccompanied. This was consistent with the earlier finding that many did not disclose to anyone. Friends or relatives accompanied a few. Survivors presented directly at the outpatient department or casualty. Some survivors however first went to dispensaries, health centres and private clinics where they were offered limited services and referred to the two hospitals. Once at the facility, survivors reported varied pathways within the hospital. Most reported at least three different service delivery points they had to go through, with some reporting up to six different service delivery points.

While the services offered were similar, the process differed across the two hospitals. In Naivasha Sub-county Hospital, the services were offered across different departments situated in separate buildings within the hospital grounds. Survivors were directed to see clinicians at the outpatient department, go to the laboratory, counselling and pharmacy all located in different buildings ranging from a few metres to over 100 metres apart. In Thika Level 5 Hospital, all services were provided at the HIV CCC (except on weekends and at night when services were offered at the outpatient department). The CCC comprised of two buildings adjacent to one another with different services offered in separate rooms.

The flow of survivors within the hospitals and services at different service points is illustrated in figure 6.1. Upon arrival, all the survivors had to register. Many reported that registration was often confusing and not clearly outlined. Some reported queuing in the wrong place only to be told to go somewhere else while others reported paying for registration only for the doctor to tell them to go and claim their money back as they were not meant to pay. One survivor said of her experience,

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“Ok, I started by going to get a card [registration], the person I found did not know where I had come from so he asked me for money to pay for the card. When I got to the doctor, I showed him the card, he said I was not supposed to pay. So he sent me back. Although I was not given back my 50 shillings, I was told it shouldn’t be paid.” (Survivor, NSV05)

From registration, survivors were sent to the consultation rooms where they were first triaged by a nurse and then seen by the clinician. The clinicians who treated the survivors in both hospitals were mainly clinical officers but on some occasions, a medical officer could be called to see the survivor. Once seen, survivors were sent to the laboratory where specimens were collected. The specimens were for various tests: haemoglobin, hepatitis B surface antigen, liver function, urine microscopy, syphilis and pregnancy. They were also issued specimen containers for other specimens such as high vaginal swab or anal swab. Survivors then either went back to the same clinician to have this specimen collected or to a different room where someone else, generally a nurse, collected the specimen. Once the specimen was collected, they had to ferry it back to the laboratory, wait for the results and take these back to the clinician. The survivors were also sent for HIV testing which was preceded by pre-test counselling. This was often independently conducted in a different room from other laboratory tests. Once the results were ready, the survivor went back to the clinician who prescribed treatment and referred the survivor for trauma counselling. The survivor then proceeded to the pharmacy to pick up treatment and to the nurse counsellor for counselling.

“I first went to see the doctor and when I told him he said I should go to the lab first, so that they know if I was already infected because they asked me the last time that I had tested [for HIV] [...]. So he told me it is good for me to go for testing first before he takes me to the next step. I went for the test and they found that I was okay so I took the results back to him [...]. When my results were out and I was negative, that’s when now I was sent back to the counsellor [...]. She gave me a prescription to be given a drug for that particular day. So, on Tuesday morning, I was to come back for counselling.” (Survivor, NSV 13)

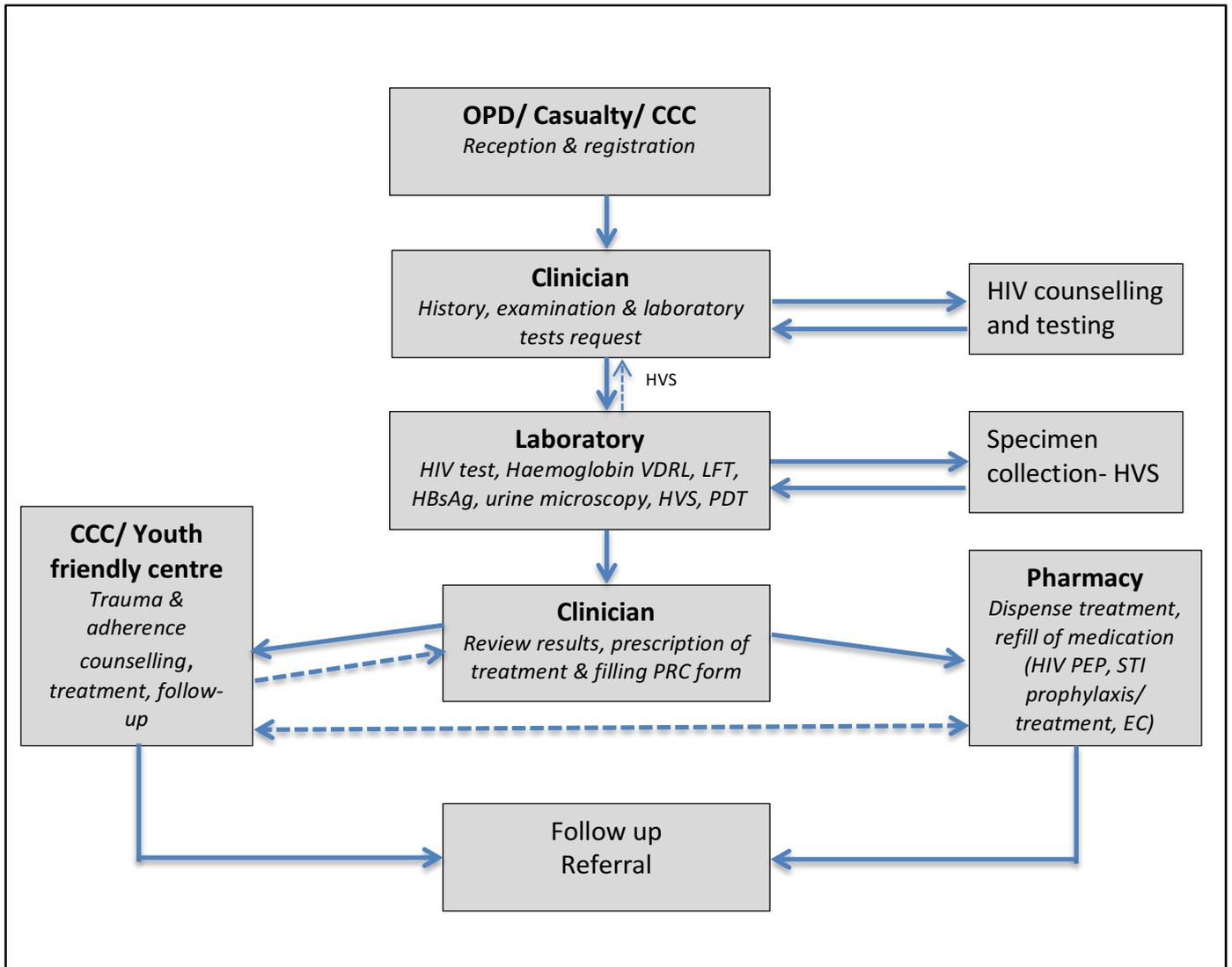


Figure 6.1: In-hospital flow of survivors and services provided

Solid arrows represent the most common pathways for survivors; dotted arrows represent alternate pathways

Abbreviations:

CCC: Comprehensive care centre EC: Emergency contraceptive
 HBsAg: Hepatitis B surface antigen HVS: High vaginal swab
 LFT: Liver function test OPD: Outpatient department
 PDT: Pregnancy detection test PEP: Post exposure prophylaxis
 PRC: Post rape care STI: Sexually transmitted infection

Although this was the most common flow path of survivors, the process was often not linear. Sometimes counselling was received before the survivor went to the laboratory or before they went back to see the clinician for a prescription. At times the first stop for the

survivor from registration was HIV testing or the nurse counsellor who then escorted the survivor to the clinician.

I came and I was told to go to the cashier's and tell them my name and they will give me a card [registration]. That card is what I will take to the doctor and I tell him what has happened. That is what I did and the doctor sent me here to the youth centre [for counselling] and I was advised, she told me what I am supposed to do. After that I went for treatment I was told how I should take the medicines, when to come back, that was all." (Survivor, NSV11)

"I just entered the room that is there [outpatient department] and I was done a finger test [HIV test][...] I was tested first." (Survivor, TSV02)

In Thika Level 5 Hospital, survivors were not required to wait for laboratory test results on the first day but instead had to come back for them after three days. Once the initial visit was complete, the survivor was scheduled for a follow up visit. From these two centres, survivors were rarely referred elsewhere. Very few survivors reported being referred to the police, social worker or any other support services.

6.3.6.2 Challenges along the hospital process and services

A considerable proportion of survivors reported multiple challenges during the process of accessing care in the hospital. These challenges centred on the survivors' interactions with the healthcare providers and location of services.

Lack of informed consent: The process of informed consent that is clearly outlined in the treatment guidelines did not feature in the survivors' narratives of their experiences at the hospital. The fact that some survivors did not know what the procedures and tests done or the medicines they were given were for also suggests an absence of informed consent.

Survivor: *He [clinician] asked me questions, how it happened, where, what time. Then afterwards he sent you to the lab. He sends you to the lab, when you go to the lab, you are given some other things to take to another doctor, this doctor is the one who collects specimen. Then you take the specimen back to the lab. Then you have to take it [results] back to him [clinician] then he gives you medicine [...].*

Interviewer: *So the medicine you were given, how long did they last?*

Survivor: *Two weeks. There was the injection [...] Two injections.*

Interviewer: *What were they for?*

Survivor: *I don't know because even they were so painful.*

Interviewer: *Okay, so you didn't ask them what they were injecting you?*

Survivor: *So, I think they were, I don't know to prevent whatever- I didn't know.
(Survivor, NSV12)*

Judging by this survivor's description and that of others, survivors did what they were told to do without questioning and the HCPs rarely explained the procedures or the reasons for the procedures to them. The majority of the survivors reported they were sent to the laboratory for blood, urine and vaginal swab but did not comprehend what specific tests were being carried out on these specimens.

Long duration waiting to receive services: Four main waiting areas in the process of healthcare were reported: waiting to be seen by a clinician, waiting for laboratory tests, waiting for counselling and waiting for medicines. There was a policy at the hospitals to fast-track survivors without having to wait in queues. However, this did not always happen due to various reasons: 1) the HCPs attending to survivors also attended to other patients, 2) the survivors were generally unaware that they did not need to queue, and 3) there was no unique way of identifying survivors and making the HCP concerned aware that a survivor was waiting for services. The hospitals relied on survivors to identify themselves and this did not always happen.

There were mixed reports regarding waiting to be seen by a clinician. While many survivors reported they did not have to wait long to be seen, several reported extended durations of waiting. Waiting time was dependant on the time the survivor presented (with longer waiting periods during busy hours); whether the clinician was available immediately; and, other patients being attended to (with for instance road traffic accident victims being given priority). The definition of 'long waiting time' was arbitrary and varied greatly between survivors. Some survivors who waited for about thirty minutes to be seen reported that as a short time while others who waited for a similar period thought it was a very long time to wait. In some cases such as the one described by the survivor below, it was obvious the survivor had spent a huge amount of time waiting:

“I queued from six o’clock [in the morning]. At that point [registration] I paid fifty shillings, on going back I was told that people like me shouldn’t pay. So I filled the patient’s card then took it back and I was given another one. I was then told to come here but I found there was no one [meaning no clinician] but I met the lady who has just entered [referring to the nurse counsellor], that lady held my hand [meaning helped] and called the doctor, she told the doctor that there was a patient, but the doctor was held up somewhere. We thought she had gone for lunch and will come back, but when she [nurse counsellor] saw she would be late she called the other lady and told her to take me to another place [to be seen by a different clinician]. So I was just taken to another place, it was around four o’clock in the evening.” (Survivor, NSV014)

The laboratory was the main area where many survivors reported long waiting times. The long wait was frustrating to survivors and led some to consider leaving the hospital without the services.

“I went to the lab, I was told to wait outside, so I went and sat with the other people and waited. Then I started getting stressed because I had heard that you need to get treatment without delay [...]. So I went back to the doctor who had sent me to the lab but I found he had another patient. So I went back to the lab and decided to show them the note I had been given [her referral from another hospital indicating rape] so that they can assist me quickly. After I showed them, they started asking me many questions [...]. Then they gave me another thing for taking the specimen and told me to take it to another room where I found three ladies. Now things were even worse here. They told me to wait outside and then they started talking [...]. I waited for almost three hours [...]. Then I went back to the lab but I was afraid of what to say in the lab so I went back and waited [...]. You can imagine it got to 2 pm and I had arrived at 10 am. So I started thinking I should go back to [name of private hospital where she had been referred from] and ask them to refer me elsewhere.” (Survivor, NSV07)

The way certain services were structured also contributed to waiting or receiving partial services. The counsellors for instance were only available during normal working hours from Monday to Friday. Survivors who presented late in the evening, at night, on weekends or during public holidays were advised to come back when a counsellor was available. Even when the survivor presented within working hours in the hospital but was late while being attended in other departments, they were required to come back the next day as this survivor explains:

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“There was a long queue. I got here about eight [...] but I was delayed at the lab before getting the results. While exiting, I was told to go back to the doctors’ room. You can see, that going back to the doctor consumes time. It was about 5:30. When I come back to [name of counsellor], she was preparing to leave; she gave me a prescription to be given a drug for that particular day. So, on Tuesday morning, I was to come back for counselling.” (Survivor, NSV13)

This was also the scenario in pharmacy where survivors presenting outside normal working hours were issued with medicines for a few days until they could come back during normal working hours. Getting partial treatment has the potential to contribute to failure to complete treatment. In addition to returning being very inconveniencing, competing priorities could compromise the ability to attend refill visits.

“Coming at night and then again in the morning was not exactly fair, not fair, coz we left here at around four in the morning. Then the next day I had to wake up early. I’m so tired, but either way I had to come for the medicine [...]. I would have preferred taking all the medicines at night then at least I would have had more time to rest.” (Survivor, NSV02)

Multiple service delivery points contribute to delays and psychological trauma: As indicated above, being sent from one department to another caused delays. In addition, it amplified the distress survivors were already going through in several ways. Because there was no unique way of identifying survivors, they often had to identify themselves in every department. The HCPs often asked “many questions” and required survivors to explain to them their situation and this involved retelling their story, which was traumatic.

“And about the walking here and there, it would obviously be easier if it was a specific place or office, let’s say it is here, that you receive everything. If you have to go for the tests, you are just sent from here to the lab. Instead of having to walk through the doctors, then the counselling and whatever, and you have to be asked what happened, why, how, the experience, you know, it’s not fun. Have a specific doctor to cater for those things. So it would be even more comfortable because when I’m coming next time I want the same person.” (Survivor, NSV02)

Another major source of discomfort (and this was related to the aforementioned fear of being labelled HIV-infected) was receiving services in the HIV CCC. The CCCs are usually designated areas where all HIV infected patients are treated. In most health facilities, they are separate buildings that are clearly marked. Although the original idea for having these services separate was to keep the confidentiality of those who are HIV-infected by offering them services away from the other patients, they may end up doing the opposite. As both patients and staffs know what the CCC is for, being seen as a patient at the CCC almost certainly means being HIV-infected. HIV is highly stigmatised in the country and most people who are infected do not disclose their status. In both facilities, survivors were either treated fully at the CCC or were sent to pick up their HIV PEP treatment from there. This is a common practice throughout the country as antiretroviral drugs used for HIV PEP are almost exclusively stocked in the CCC pharmacy. Many survivors expressed their distress at being sent to the HIV centre. In situations where doctors did not explain why the survivor was going to the HIV centre, the fear emanated from the survivor assuming they were being sent there because they were HIV infected. More commonly however, the fear was of meeting someone known to them who might conclude that they were HIV-infected and were there to collect their treatment and go tell others in the community. This fear has the potential to deter survivors from going to pick treatment as this survivor explained:

"I was under a lot of stress standing there [at the CCC]. I was thinking to myself my colleagues will pass by on their way to work and they will say I have the disease [HIV]. Shortly, another lady we work with came to pick her medicines [meaning ARVs] [...]. Let me tell you, when you enter through that door [CCC], you tremble. I was very afraid; if it were not for her [nurse counsellor], I would not have completed my treatment. If she had told me to go and not bothered herself [to accompany the survivor to CCC] I would not have picked the second dose."
(Survivor, NSV07)

Staff attitudes: Survivors also judged the services they received based on their interactions with the HCPs. Interactions with HCPs such as how they received the survivors, how they talked to the survivors, and the kind of information they gave or failed to give were a major reference for survivors when commenting on how satisfied they were with the services. Being received promptly at a service delivery point, HCPs

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displaying sensitivity and empathy increased survivor satisfaction. The Majority of survivors reported being satisfied with the services provided. Many of them reported that the staffs were friendly contrary to what they had expected. They also found the healthcare provided very useful as illustrated by this survivor:

“Okay, it was okay, it was fine especially the advice, you know when I came I was down, I was feeling like, I wouldn’t have come here I take away my life but at least they gave me hope.” (Survivor, NSV04)

As with the above survivor, many singled out counselling as one of the main components of healthcare they had really appreciated and found very helpful. This was mainly related to how the counsellor handled the survivors. Many described how the counsellor had not only taken time to explain things but also went out of her way to escort survivors to different service delivery points and intervene in areas where they had difficulties. This reflects on the importance of engaging with the survivor, being empathetic and providing adequate information. The data illustrates that interactions with HCPs have the potential to determine whether a survivor completes treatment or not.

“Sometimes I had abdominal pains, sometimes diarrhoea but I was told during counselling there are those side effects [...] I finished all of them.” (Survivor, NSV08)

“I didn’t like that doctor at the pharmacy. That one told me, “you, can you be raped as an adult? Or it is just the way you people go and agree then you come and claim you were raped”. So you see, I thought if I come back I might be sent back there and I might find her there, so I decided not to.” (Survivor, NSV09)

As demonstrated by the above two survivors, the first one completed treatment as a result of her interaction with a HCP who provided adequate information. Because the HCP had explained what side effects to expect from the treatment, she persevered and completed the course. In contrast, the second survivor failed to complete treatment because of the attitude displayed by a HCP. The HCP’s attitude conveyed doubts about the genuineness of the survivor and this made her fear returning in case she encountered the same accusatory attitude.

6.3.7 Follow up

Having looked at the experiences of survivors before seeking treatment and through the hospital process, this section now explores the experiences of survivors through the treatment follow up as well as other individual and community-level experiences following violence. These are presented under three subsections: Experiences taking HIV PEP; scheduled and unscheduled return visits to hospital; and, community support available.

6.3.7.1 Experience of taking HIV PEP

All the survivors who presented at the hospital within the recommended time and disclosed violence to the HCPs were started on HIV PEP. However, among those survivors who should have completed HIV PEP by the time of the study, more than half failed to complete the course. Survivors reported a variety of experiences with regards to taking HIV PEP. Fear of getting HIV infected was a strong motivating factor to complete treatment.

Survivor: I can say my stomach was not exactly accommodating them properly. So you can't eat well, sometimes you don't even eat. You feel like if you eat everything will come out at the end of the day. Sometimes you take the medicine and you end up throwing up.

Interviewer: Ok, and did you finish the medicines?

Survivor: Yeah, I did. If you think it is a risk of getting HIV or not, I'll have to take them either way. (Survivor, NSV02)

As in the case of this survivor, side effects were commonly reported. The side effects reported included headache, nausea, vomiting, abdominal pains and diarrhoea. One survivor also reported getting visual hallucinations. The side effects were at times severe enough to interfere with normal daily function leading a few survivors to miss work.

Survivors also reported serious difficulties in scheduling time to take HIV PEP. For some, it was the conflict between the time the medicines were to be taken and reporting to work. Because survivors were supposed to take the medicines twice a day, in the morning and evening, the timing often clashed with the time they reported to work or came back home. In addition some felt the need to hide their treatment from either a spouse if they

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had not disclosed the violence to the spouse or the employer and colleagues for fear of being labelled HIV infected and facing possible discrimination. As this survivor explains, this hiding was difficult and also meant that at times, she could not take the medicines at the right time:

“I took them for 28 days; I had a very hard time. When I came here, I was told I must take them in the morning and evening, but you see am employed [as a domestic worker]. At times you have to hide when taking the medicines because you don’t want them [employer] to know you are taking medicines. They will ask you what they are for. If you tell them, the employers are very different, they will think the way I have told you [that you have HIV], they will think you will infect them even though it is not contagious. Let me just tell you the truth, I had a hard time wondering how to take those medicines. Also, I will forget the timing, and if I forget they won’t be useful, right?” (Survivor, NSV03)

Reasons for not completing HIV PEP: Among survivors who did not complete HIV PEP, side effects, not being aware of the full course of treatment and being too busy to return for refill were cited as the reasons for not completing the treatment.

With regards to side effects, there was a sharp contrast between how survivors reacted to the side effects depending on what information they had. Having information regarding what side effects to expect was helpful to survivors and enhanced treatment completion.

“When I came they received me well and gave me medicine though the medicine had a lot of side effects. I was not feeling well, I used to puke on seeing the pills even when I have not swallowed. I did not complete the dosage because I was supposed to take for 28 days but I only swallowed for 10 days. I had been given for 14 days and I was supposed to come back for the dosage for another 14 days. So I stopped taking the medicine and told God to help me because I had tried taking the medicine and I was unable to. So I just told myself to stop and hope that God would help me [...]. I did not come [back to hospital] because even if I came I knew I would be told to continue taking the medication.” (Survivor, NSV13)

As the above survivor points out, she did not go back to the hospital when she developed side effect because she feared she would be told to continue with the same treatment. This is a pointer to both lack of adequate information and a fear of healthcare providers.

Going back to the hospital and discussing her situation with the HCP would have possibly led to a different outcome through getting information on how to deal with the side effects or being prescribed for alternative treatment. In contrast, another survivor explained that even though she experienced side effects, she persisted taking the medication because she had been made aware that side effects were likely to occur.

Another survivor similarly cited lack of information as the reason for not completing treatment. In her case, the survivor reported that she was not aware of the duration of treatment. As she was not informed she needed to return for refill she thought the course issued for two weeks was the complete dose and therefore did not find it necessary to come back once she completed the two weeks. These cases illustrate the importance of adequately preparing the survivors for adherence to treatment by providing important information not only on treatment side effects and duration, but also on what to do if these side effects develop including returning to hospital to inform the HCP before stopping treatment.

Several other survivors failed to complete treatment because of being busy at work or being occupied by more pressing personal issues such as searching for a job and therefore could not return for refill.

“Okay my own reasons [for not returning for refill], that time I was so desperate I didn’t find the reason of coming back personally because that time I didn’t have a job, now the issues that I had in my head is looking for a place to work.” (Survivor, NSV04)

6.3.7.2 Return visits

There were several scheduled return visits. The number of visits varied depending on whether you were seen during the normal working hours (8-5pm on weekdays) or outside these hours. For those who were eligible for HIV PEP, a prescription for 14 days was issued on the first day and survivors scheduled to come back for the rest after two weeks. However, for those presenting outside the normal working hours, a prescription for a few days was given and survivors were required to return the next day or in a few days’ time to get additional tablets to complete the 14 days. In Thika Level 5 Hospital, survivors were also scheduled to come back after three days for laboratory tests results. After the two

weeks visit, survivors were scheduled to return after 4-6 weeks, three months and 6 months.

Of the 17 survivors who initiated treatment, 13 (including some who never completed HIV PEP treatment) returned at least once. Several themes emerged around factors contributing to returning or failing to return for scheduled visits. These included fear of HIV, not being aware of the need to return, competing priorities, inconsistencies in healthcare providers and preference for other facilities.

Fear of HIV: Fear of HIV infection was frequently mentioned as a motivator for both seeking healthcare and returning for follow up. Nearly all the survivors who went back to the hospital upon completion of treatment did so because they wanted to get tested for HIV. Even those survivors who did not go back to the two hospitals found ways of checking their HIV status through voluntary counselling and testing centres or private hospitals.

“I was given medicine, but now the reason why I did not come back, I was not told if I am supposed to come back. So I thought after that it is like that and then I left. But later on, I came of my own volition. But I didn’t come here. I came to the voluntary counselling and testing centre. Just to know myself. I came, though I can’t remember when. I came back, I was tested. It turned out negative, you know it is just that you are worried.” (Survivor, NSV12)

Similarly, nearly all the survivors who initially did not seek healthcare went to test for HIV in different facilities later.

“When I was raped, ok it was too late before I knew I had to go to a hospital. So, like it was hard to share with anyone what happened to me so I just stayed. Then one day I thought, maybe the person who raped me might have had the disease [meaning HIV], let me go to a hospital [to be tested], I went to [name of hospital].” (Survivor, WSV06)

Competing priorities: Competing priorities were the main reasons survivors did not come back. These priorities were primarily linked to financial insecurity with work being the most commonly mentioned. The work place being too busy and therefore not getting time off to come back for refill of medication or counselling was cited. Other than being

unable to get time off work, being busy with other personal issues including looking for jobs also led survivors to miss appointments.

“Sometime you go to work and go back home when it’s late. You leave for work early in the morning and you know where you are employed to ask for some time off, they deny you and even ask you to come to work earlier and then you get home late.” (Survivor, NSV13)

“Okay my own reasons, that time I was so desperate I didn’t find the reason for coming back personally because that time I didn’t have a job. Now the issues that I had in my head is looking for a place to work.” (Survivor, NSV04)

Preference for other facilities: In other instances, a few survivors preferred to continue with healthcare elsewhere rather than coming back to the hospital. Those survivors who went elsewhere reported they took that choice for convenience therefore preferring facilities that were nearer to their residence or at their work place.

Survivor: *I did not come because I was busy at job so I could not get time to come back*

Interviewer: *Ok, so you have never come back since that time.*

Survivor: *Yeah*

Interviewer: *Ok, so did you ever go back to have your tests done?*

Survivor: *Yeah, because in my company after two months we used to go for tests [...]. At the company, they used to bring doctors they examine us then after that they bring the results [...]. I stayed for two months then I went for the test. (Survivor, NSV06)*

In contrast to the above survivor, another survivor who similarly struggled getting time off to go back for follow up declined to use the services offered at her work place clinic for fear of stigma:

“Because she [nurse counsellor] asked me to come, I thought if I tell them [employer] I am going back to the hospital they might refuse and you can’t tell them your problem [rape]. You tell them you were raped they will ask you, why didn’t you report to our hospital you went there.” (Survivor, NSV07)

The above two survivors differed in that the survivor willing to use her work place services had disclosed her rape while the second survivor had not. This is a clear

indication of the role that non-disclosure particularly due to perceived stigma may play in the healthcare choices of survivors.

Being unaware of the need to return: Lack of clear information on the need for follow up visits contributed to missed visits. A few survivors who did not come back for scheduled visits indicated that they were unaware that they were meant to come back. According to them, no one informed them they were meant to come back, hence they assumed the initial treatment issued [usually a two weeks prescription of HIV PEP] was the complete dose. This was an indicator that either the healthcare provider did not provide this crucial information or the survivor did not understand the information provided.

“I was given medicine, but now the reason why I did not come back, I was not told if I am supposed to come back.” (Survivor, NSV12)

Lack of continuity of care with the same HCP: Lack of consistency in the HCPs attending to the survivors was also mentioned as a contributing factor to one survivor dropping out of care. She explained that she found it difficult to connect with a new HCP once she had gotten ‘used’ to a different one. In spite of her need to continue with counselling, this change of HCP made her stop going to the hospital.

***Survivor:** Well, I’ve not been here [meaning counselling] in a long time but I might be.*

***Interviewer:** You might be- do you think you want to come back?*

***Survivor:** Yeah, definitely. Though you know it is different. The lady at the front was not this one, there was a different one. I was informed she was an intern. So I had already gotten used to the other one*

***Interviewer:** Oh, the other one, the intern?*

***Survivor:** Yes, so when I came and I was told that she was not here anymore, I kind of disappeared. (Survivor, NSV02)*

While the majority of survivors did not cite this reason as contributing to failure to come back, her feelings echo the majority of the other survivors’ expressed desire to have services provided at one place and preferably by the same person. This would reduce the need for them to retell their story to many different healthcare providers.

6.3.7.3 Community support

There were minimal community support mechanisms reported. Community support was limited to individual support from friends and relatives rather than organised support. The only organised support reported was in the form of peer support groups. Other survivors or a CHW invited survivors to these support groups. The groups mainly offered psychosocial support and training on income generating activities. Those attending these support groups found them helpful especially because they helped them connect with people who were going through the same experience.

“Now there is a group I want to join in Nairobi. Because I am doing computer, there is a group there, they help you, they help people, they give them advice [...]. About how you can overcome it [overcome the violence], they keep you busy, there are people who teach tailoring [...]. They told me things they have gone through, some of them have, two of them have children, one told me she was chased away by the mother.” (Survivor, NSV01)

In these groups, survivors met others who were struggling with the same things they were and who could therefore relate to their problems. Speaking to someone who had experienced violence was especially helpful as the knowledge that ‘you are not the only one’ helped survivors move on. This not only helped survivors accept their situation, but also helped deal with some of the consequences of the violence such as children born of the violence.

“It [group] has helped in thoughts and in accepting the child so I started healing [...]. I realised I had been unwise [by not disclosing], am not the only one, we are more than 10 people in the group [...]. So I realised when you have such a problem, you shouldn’t keep quiet [...]. It has helped me to accept myself.” (Survivor, WSV05)

Like this survivor, there were some survivors who had not disclosed to anyone initially but observed that they found talking to someone very important. Other than sharing experiences, survivors also learnt new skills in the support groups. These skills included tailoring, knitting, making soap and table banking where survivors contributed money and loaned it to members. In this way, the support groups provided an avenue for empowerment. Being able to learn new skills helped survivors stay busy thus taking their minds off their experience and also earn a living as this survivor explained:

“What we were doing to progress is like knitting, you bring your wool. Then we also learnt how to make soap [...]. They tell you when you go home, you can make your own and sell. You create your own job. Since I learnt how to knit, it is like I have employed myself.” (Survivor, WSV05)

6.3.8 Survivor perceptions of effects of violence and care seeking for related complications

Violence was perceived to result in both health and non-health related consequences (table 6.2). Nearly all survivors reported their lives had changed significantly after experiencing violence. In addition to the direct physical effects, the violence often set off a cascade of many negative psychological, relationship and financial outcomes. Survivors mentioned many health-related effects that they felt were a direct result of the violence. The majority of those who reported health symptoms had recurrent episodes which some sought treatment for. However, many did not go to the hospital for treatment, opting instead to wait out the symptoms or buy over the counter medicines for the symptoms.

Pregnancy: Pregnancy as a direct result of rape was reported by several survivors. Pregnancy was particularly common among the survivors who did not seek healthcare for the violence. Four out of the seven survivors who did not go to the hospital immediately or went but did not disclose having been raped reported getting pregnant and bearing children after the rape. In contrast, none of the 17 survivors who sought healthcare reported pregnancy.

“I just took a bath [after the rape] and life continued as usual. I did not report anywhere. Then, after like three weeks, I started feeling pain, I started feeling unwell. Then I started vomiting and later found out I was pregnant.” (Survivor, WSV02)

Sexually transmitted infections: Only one survivor was diagnosed with specific STIs- syphilis and HIV infection- which she linked to the rape. Others received treatment for genito-urinary symptoms but did not receive a specific STI diagnosis. Some of those who received symptomatic treatment did not reveal to the HCP that they had gone through sexual violence.

“I just went to another private hospital called [name of clinic]. At that moment I used to scratch my private parts; I went and saw that doctor, he prescribed for me five injections. He injected me. But I didn’t tell him that I had been raped.” (Survivor, WSV01)

Other survivors reported symptoms that could be suggestive of STIs such as low abdominal pains and vaginal discharge but did not seek treatment for these symptoms while others preferred to self-treat with over the counter medicine.

“I started having severe abdominal pains, having a bad smelly discharge, I went to a chemist and bought some drugs and I got better. But the problem came back about two months ago, again I bought medicines. I was wondering, is it going to be like this always.” (Survivor, NSV09)

Other physical symptoms: Various other physical issues were reported by nearly a third of the survivors. Similar to pregnancy and STIs, the majority of these survivors did not seek treatment. These included headaches, faecal incontinence, bleeding, long-term general body pains and weakness. One survivor reported having been subjected to female genital mutilation during the incidence and therefore lived with the scarring and psychological trauma.

“I have been having headaches, but I think my head is aching because of thinking too much.” (Survivor, NSV05)

Psychological effects: Psychological problems as a result of the violence were common in nearly all the survivors. These occurred both in the short term and long after the violence. Survivors reported being more anxious, stressed, bitter and temperamental. There were also feelings of shame, guilt, regret and blaming oneself for the violence. Fear was particularly prominent among the survivors. Many were afraid of darkness and reported being afraid of walking at night or staying in an unlocked house. Similarly, many were afraid of men, perceived all men as potential perpetrators of violence and therefore took steps to avoid them.

“But even now, if you are in a relationship, you start to remember what happened. You feel like all men, in fact I tell people, please, all men are the same. You are just made from the same mother. So now you cannot trust anybody [...]. There is somebody I told I wish I did not have that organ. Because if it were not for that

organ, that person would not have taken advantage of you [...]. From that I even now hate sex the more.” (Survivor, NSV12)

These strong feelings against all men not only prevented women from getting into relationships but also affected those already in relationships. Married survivors found it difficult to engage sexually with their husbands. While survivors found it difficult to trust men, survivors reported that their partners also found it difficult to trust them after the violence. Sometimes, the partners blamed the survivor for the violence or did not believe the survivor leading to strained relationships as this survivor explained:

“At times that bitterness, not that I have done anything, then maybe he [husband] thinks I have done something. In fact that made me stop going for my job at the airport, because he used to say those are my friends who I work with. That I should stop saying they raped me, those are my friends.” (Survivor, WSV03)

Relationships beyond sexual partnerships were also affected. Relating with other people in the community was also reported to be difficult with some survivors wanting to be “left alone” to deal with their problems. How survivors related with their children and how they parented them also changed significantly after the violence. The survivors’ inability to trust other people, particularly men with their children was evident in the way survivors raised up their children. Many of them feared for their children and constantly worried that their children might go through what they had gone through. They took precautions to ensure their children were safe. These precautions included talking to their children about men and against receiving gifts from them, always making sure they knew their children’s whereabouts; and, preventing their children from being in close contact with men including forbidding girls from playing with boys. As this survivor explained, no man, not even the child’s father could be trusted:

“But when I got daughters, I have become the kind of person if they go outside, I have to check where they are, what they are doing. You see, when my child goes out, I suffer [...]. The way I was abused when I was a child, 14 years, that affected me because I see as if my daughter can go through what I went through. She can go out and be assaulted or you might leave her at home and even her father might assault her [...]. I see as if all men are the same.” (Survivor, WSV03)

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“I tell her [eight years old daughter] she is now a lady, a b c d can happen to her, not to accept sweets from strangers and what, I talk to her.” (Survivor, NSV12)

Despite the majority of survivors reporting psychological and relationship problems and some expressing a need for support, many did not get help. There was limited support at the community level to deal with psychological issues. A few survivors received counselling from a community health worker. One survivor received a referral from a community health worker to the local health facility for counselling services. While multiple survivors reported strained relationships with their partners, only one survivor reported discussing her problems with anyone or receiving any help. Even for this survivor, help was in the form of intervention by family members to reconcile her and her partner after their relationship broke down.

“I went and stayed then my husband came. When I explained to him [about the violence], it is like he did not want to understand me. I stayed for a while then I left and went back to our home [meaning her parent’s home] [...]. After some time, elders from my side and elders from his side came and talked to him so I went back.” (Survivor, WSV03)

Financial consequences: For a significant proportion of survivors, financial difficulties were a common consequence of the violence. These were either directly related to inability to get or maintain a job or indirect due to effects of violence such as a child born of the violence. Some survivors reported being too weak physically or too traumatised psychologically to go to work. Some were afraid of reporting to work fearing that everyone at their workplace knew about their experience.

“You know even the job I was doing I stopped. Once that happened [rape], you are not able to go to work another day, you think if you go, everyone knows. Your thoughts tell you everybody knows but they don’t, in your heart you think they know, so I stopped going to work and stayed at home.” (Survivor, WSV08)

Similarly, one survivor had to relocate from her home as she could not endure living in the same environment, several changed careers and one reported dropping out of school. Children born of rape were a major financial burden especially for women who were

single. These women had to cater for a child they had not planned for, often in addition to children they already had.

“You know I didn’t want another child, but now that the child came, what could I do? [...]. I had three children [...]. It has affected me because you see the way life is hard nowadays, now I have been given another burden I wasn’t expecting, and there is no one who can help me, the child is mine and life has to go on.” (Survivor, WSV02)

Nevertheless, the burden of an additional child was not experienced by the single women only. One survivor was married but she constantly lived with the fear of abandonment and financial insecurity. Although her husband supported her, he was cruel to the child and kept threatening to kick her and her child out. This kind of abuse also had long-term emotional effect on both the child and survivor.

“It also affected me by giving birth to a child that does not belong to the man that has married me. Then he mistreats and insults him all the time and things like that. If you try telling him not to insult or harass the child, he tells me that I will take the child and move out with him.” (Survivor, WSV01)

Table 6.2: Effects of violence experienced by survivors

Summary of effects of violence reported by survivors			
Physical <ul style="list-style-type: none"> • Pain- headache, abdominal & other body pains • General body weakness • Pregnancy • STIs- HIV, syphilis • HIV-related complications • Chronic vaginal discharge • Stool incontinence • Bleeding • Scarring 	Psychological <ul style="list-style-type: none"> • Stress • Insomnia • Fear of HIV • Fear of darkness • Self-blame • Loss of self-confidence • Overreacting • Guilt • Shame • Bitterness 	Relational <ul style="list-style-type: none"> • Dislike of men • Loss of interest in men & sex • Fear of men • Worsening spousal relationships • Distrust • Over-protective parenting 	Financial <ul style="list-style-type: none"> • Loss of work • Difficulties performing work • Dropping out of school • Childcare- for children born of rape • Relocating/moving house

6.3.9 Survivor perceptions of additional care needed

In addition to the services available at the hospital, police and the community, survivors identified additional services that they felt would enhance their care and areas where existing services could be improved.

Additional support during treatment and beyond: Most survivors suggested a closer follow up and additional support during and after treatment. Psychosocial support was identified as being especially important but it was currently not adequate. Survivors expressed the need for counselling to be more available at the hospital when they present and during follow up. Survivors noted that counselling was important and equipped them to deal with the aftermath of the violence. Psychosocial support should also be available at the community level.

“What I can say is, when this happens [rape], one gets too many thoughts and you feel as if you might leave people [meaning die], so what I can say is they need love, show them love, like in that group (peer support), continue talking to them showing them love and they are not the only ones. I usually say if the government was able to help such people since some don’t have jobs, they have children [...] and you see their bodies are weak and the thoughts are still disturbing, such a person might think they have no life [meaning their life is not important].”
(Survivor, NSV03)

More accessible and comprehensive services: Streamlining services within the hospital make it possible for survivors to access services more easily. Service provision in a centralised place would reduce the need to move from one department to another and the time taken to receive services. Likewise, it would reduce the need for survivors to keep explaining their story to different service providers and make follow up more efficient. A few survivors also suggested reducing the number of follow up visits for instance by issuing all treatment on the first visit.

“Starting with the issue of having to come back again, I think it would be easier if they would have ...ok, I know you have to come back for the medication after 14 days, but it’s better if you give the medication at the time that the patient is here. Because you never know, maybe she might not make it the next day, though it is risky according to what they told me. She might within those- it might not be convenient. So it would be easy if they issue the medicine when the patient is available. Tomorrow might never come.” (Survivor, NSV02)

Judging by the fact that a few survivors reported that they failed to complete treatment because of inability to return for refill due to competing priorities, this strategy of offering treatment at the first visit may enhance completion in some survivors.

A desire to have the services brought nearer to the people and made more accessible through offering a 24-hour service was expressed. This would enable survivors to access care without having to travel far. A 24-hour service would ensure survivors could be attended to at any time when the violence happens. In addition, survivors who may not be inclined to seek services during the day for fear of others knowing can do so at night as this survivor explains:

“Like in our area here, we have a health centre nearby. We would like to have a room specific for rape cases so we don’t have to take those cases to [name of regional hospital] or elsewhere. It should be here near the people and people get to know about it. People should be made aware there is such a clinic. If you have such a problem, there is somewhere you can go. You know people usually fear being told to go to report. So, if these CHWs know and they know there is a hospital near [where they can refer survivors], and it should operate 24 hours because some fear going to hospital during the day so they will go at night because they don’t want other people to know they have gone for treatment. So it should be 24 hours, like in this area it will help.” (Survivor, WSV05)

In addition, a possibility of ‘escape’ from the rape situation for a few days was also suggested as desirable especially for those survivors who experienced violence within their homes. As this survivor explains, this would give a survivor some time to recover from the trauma away from the scene of trauma:

“What I would like is if there was like an admission for rape cases, you are told to remain there even if for two days only. It would be good, so that the incidence can get out [...]. Instead of going home, if you go back to the same house [where the violence happened] it will affect you. You see like me it affected me and my sisters realised [it had affected her] so we had to move [meaning shift from their home to a new place].” (Survivor, WSV07)

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This type of moving away was also noted to be particularly important for children assaulted by relatives or close members of the family. The importance of taking such a child away from the abusive environment was emphasised. In addition to the possibility of revictimisation if left in the same environment, healing would be difficult for the child. As this survivor notes, a rescue centre would give safety to a child and also allow time for them to receive counselling:

“Also, let’s say a child has been raped, perhaps a family member has committed that act. So for the child to heal, is there no way we can have like a home to rescue children like these? So that someone can talk to them, because if for instance an uncle has raped them, and this is the uncle they live with, you see there is no time the child will trust him. I would request like in this area, those who had such an issue, they be separated for the time being, they are talked to until they accept themselves.” (Survivor, WSV05)

Community awareness: Many survivors also highlighted the importance of awareness creation. Survivors felt that for people to be able to utilise the services effectively, they needed to be made aware that these services were available and the importance of using these services. Thus educating people would ensure that those who experience violence do not hide but instead seek medical care. In addition, educating community members provides information not only for survivors but also for other members of the society so that they know how to help survivors. Having a contact person who the community knew would make it easy for survivors to approach that person as one survivor observed:

“What I can suggest, you should increase the number of counsellors like (name of CHW) they come to the village and educate women so that that if this happens to them, they don’t just stay in the house. Also parents, like how my mother and grandmother when this happened to me [child sexual abuse], they didn’t deal with it, how they can assist their children who have gone through such a problem.” (Survivor, WSV03)

Assistance to get justice: The need for justice and streamlining the process of accessing justice was highlighted. Many survivors found the process of seeking justice frustrating. Interactions with the police were discouraging and deterred survivors from having the perpetrator prosecuted. When no action is taken on perpetrators, survivors continue to

suffer psychologically particularly when the survivor lives in the same area as the perpetrator.

“First, the perpetrators should be arrested. Because you find that at times, somebody has raped you, if they are from your area you see they are still there no action has been taken against them or they have gone and bribed [the police]. In fact, bribing has really made things bad. Like I think the way the police are handling my case, I suspect they may have been given money, although I am not sure. So the police issue should be monitored.” (Survivor, NSV05)

Non-medical assistance for survivors: Sexual violence affected the survivors in multiple ways. Many survivors found themselves isolated after the violence and social groups such as support groups were important. Others lost their sources of income and struggled both financially as well as in keeping themselves busy. A few survivors indicated that being idle amplified their psychological suffering as they had more time to dwell on the violence.

“Mostly the thing that disturbs most, without beating around the bush, resources – it is so difficult. So you see if someone had something to keep him/her busy, you just carry on with whatever you are doing, even if it is business, at least you feel you are okay; while talking with customers and different kinds of people, you forget many things that affect your feelings [...]. And may be support in assisting this child. So you know if one has not been born here, it is so different. Even though I obtained his birth certificate in the name of his step father, it is still difficult because he has not yet completely recognised the child as his own child.” (Survivor, WSV01)

6.4 Discussion

This chapter has traced the experiences of sexual violence survivors through different stages of accessing and utilising healthcare in Kenya. The main purpose of this component of the study was to describe the pathways of healthcare for survivors and outline the challenges that survivors encounter when accessing and utilising healthcare. The findings indicate varied pathways for survivors particularly between those who seek and those who do not seek healthcare. Multiple barriers and challenges encountered by the survivors along the pathways, both at the community and health facility level, were identified.

Informal disclosure of violence was a crucial step to healthcare seeking with all the survivors who disclosed informally seeking healthcare. Moreover, those who disclosed viewed disclosure as being generally helpful providing psychosocial support, support to seek healthcare and valuable advice. This is in line with other studies that have found that on average, survivors who disclose report more positive social reactions than negative ones [168-170]. In neighbouring Tanzania for instance, 78% of women who had experienced rape and also disclosed it to someone reported receiving at least one or more positive social reactions that included emotional support as well as advice to seek medical and legal services [168].

The people disclosed to and witnesses to the violence played a crucial role in the survivors' accessing healthcare, with some contributing to delays in survivors seeking healthcare. This underscores the fact that information on what to do or not after sexual violence is not only crucial to survivors, but also, because community members may influence survivor decisions, this information is crucial to them too. When many members of the community have knowledge on what to do in case of violence, more survivors are likely to receive timely treatment. Community level awareness of available healthcare services and the importance of seeking healthcare are necessary. Additionally, this study highlighted that many survivors had difficulties finding someone trustworthy at the community level to disclose to. Identifying appropriate community level service providers who survivors can not only disclose to but also get information from is crucial.

Presenting at the hospital did not necessarily mean the survivor would disclose the violence to the HCPs and this resulted in missed treatment opportunities. This finding is of great importance to HCPs. There is an on-going global debate on routine screening for gender-based violence, particularly intimate partner violence (IPV), in healthcare settings. While some studies have shown that screening is acceptable and feasible [171], evidence of effects of screening on survivor outcomes is mixed [119]. Current recommendations favour screening when relevant and in specific venues of healthcare such as sexual and reproductive health services, HIV treatment clinics, gender-based violence and recovery centres, youth centres and in conditions such as mental health disorders and substance

abuse [119, 172]. While the current screening guidelines are primarily for IPV, the finding that survivors presented to the outpatient department but chose not to disclose violence to HCPs and subsequently developed complications demonstrates that screening for non-partner sexual violence is equally important. Although there are no studies documenting the prevalence of unreported sexual violence among patients in outpatient departments in Kenya, screening in neighbouring Tanzania in an outpatient department found that nearly a quarter of the women screened had experienced sexual violence [173].

No guidelines on screening of sexual violence in outpatient and emergency departments where non-partner sexual violence survivors are more likely to present were identified in literature review. In view of WHO recommendations that discourage routine screening of GBV for all women [119], enquiry during normal clinical history taking may suffice particularly where a high index of suspicion is present. This requires more awareness raising among HCPs as well as training to recognise potential survivors and also equip them with skills to elicit such history [119]. Training is particularly important as HCPs are likely to mirror the general population, and may have some incorrect ideas about who to screen and who not to, and end up further stigmatising women. Findings of this study show that sexual violence stigma was a major issue, hence survivors may be making a pragmatic decision not to disclose. HCPs should therefore aim to create the right environment for disclosure and training of HCPs on validation and empathetic listening as recommended by WHO is crucially important [119, 174].

The hospital pathways were unclear and resulted in long waiting for survivors at various service delivery points especially the laboratory. This finding is similar to previous research done in Kenya on sexual violence services that also reported that due to this delay, a large number of survivors dropped out once they were sent to the laboratory [5]. Decreasing the hours spent waiting for treatment is not only important to decrease these drop outs, but also as treatment such as HIV PEP is time dependent, every hour spent waiting could potentially compromise treatment.

In addition to the long waiting, multiple service delivery points meant that survivors had to re-tell their experience at every service delivery point, in some instances to HCPs who

doubted them. These were sources of distress for survivors and have previously been recognised as forms of secondary victimisation [175-177]. Streamlining of sexual violence services within the hospital is desirable and would enable survivors to receive services in a more timely and efficient manner. Recounting of the violence at each service delivery point is unnecessary and training of healthcare providers coupled with better systematic ways of identifying survivors through the healthcare system can alleviate this trauma.

The need to address stigma for effective treatment of survivors cannot be overemphasised. Stigma was evident throughout the pathway of healthcare both within the hospital and within the community. It was strongly linked to poor treatment access and outcomes. Sexual violence stigma was compounded by its association with HIV. In Kenya, HIV-related stigma has been reported as a barrier to utilisation of services but studies have mainly focused on maternal health especially antenatal attendance, hospital delivery and HIV testing [178-180]. At the hospital level, a potential HIV stigma-related deterrent to treatment reported by survivors was receiving treatment in a department dedicated to HIV treatment. Therefore, facilities need to explore the best venues for providing treatment to survivors that do not subject them to stigma and consequently run the risk of missing HIV PEP. Conversely, almost universally, the survivors in this group cited avoiding HIV infection as a reason for seeking healthcare, maintaining contact with healthcare or engaging with care after initially failing to seek treatment. Therefore, healthcare providers and policy makers ought to be aware of and address this 'push and pull' of HIV on survivors particularly because the services are closely linked.

Multiple challenges were experienced during follow up. Firstly, taking HIV PEP was an unpleasant experience associated with treatment side effects and difficulties in scheduling time to take treatment. Secondly, some survivors failed to complete their follow-up appointments. Failure to return for follow-up has been reported in studies elsewhere [41, 181-183]. Survivors in Kenya are required to make multiple visits to the hospital and this increases the chances of defaulting. Competing priorities and personal circumstances were reported as preventing survivors from returning for scheduled visits. Studies elsewhere have cited factors such as distance from the hospital, costs of transport and survivor characteristics such as current mental illness, developmental and physical

disabilities as well as lack of social support as contributing to failure to complete treatment [41] [181]. WHO recommends offering all recommended services at first contact where possible [119]. Additionally, safe and accessible ways of follow up should be explored and offered to survivors. In this study, survivors identified a need to bring services closer to the community by providing treatment in local health centres and psychosocial support by community health workers.

Finally, violence had significant effects on survivors affecting them physically, psychologically, socially and financially. Community awareness of available services can create demand for these services and improve utilisation therefore preventing many of the effects of violence. Pregnancy resulting from the violence was particularly common among survivors who did not seek healthcare after the violence. This is possibly because they failed to get emergency contraceptive in comparison to survivors who went for treatment. Disclosure of sexual violence and/or pregnancy related to sexual violence early to healthcare providers is important as it creates opportunities for early intervention including provision of emergency contraceptive and termination services where available. Notably, termination of pregnancy for any reason other than when the mother's life or health is in danger is illegal in Kenya [81]; however, disclosure can provide opportunity for other support such as counselling. Moreover, studies elsewhere show that many of the women who chose to terminate pregnancy related to sexual violence did so using non-conventional methods such as herbs [184, 185]. Given that illegal abortions in Kenya are common [186-188], it is not clear how many of these may be due to pregnancy related to sexual violence. Further research on the magnitude of pregnancy related to sexual violence and outcomes of these pregnancies in Kenya is required.

Conclusions

Prompt healthcare seeking for survivors and continued engagement with healthcare is crucially important yet it is currently self-driven and riddled with many barriers that survivors find difficult to surmount on their own. More proactive ways of identifying survivors early at the community level and supporting them through treatment are warranted.

This study identified multiple barriers to accessing and completing treatment which are amenable to change with implementable interventions. Measures to address barriers at the community level can include awareness creation, addressing stigma, community level providers and establishing functional linkages with formal healthcare. Streamlining of the process of providing services within the hospital and training of healthcare providers can address the gaps identified at the hospital level. Better-structured services that include reducing the number of follow up appointments, less movement of survivors between service delivery points and easier identification of survivors through the system are necessary.

Limitations

The sampling of survivors may have limited the range of experiences reported. Recruiting survivors directly from the community would have provided more varied pathways and survivor experiences but was difficult due to the sensitivity of the subject. However, recruiting survivors from two referral hospitals and through a community based NGO enhanced the breadth of the data collected.

Sexual violence is a sensitive topic and survivors may not be comfortable discussing their experiences. Due to this, it is possible that the survivors did not give all the information regarding their experiences. To mitigate for this, I took time to develop rapport and assure survivors of the utmost confidentiality at the starting of the interview and throughout the interview.

Chapter 7: The roles of CHWs in sexual violence services, barriers to and facilitators of these services

7.1 Introduction

Having examined the pathways of care for survivors in chapter 6 and identified barriers to treatment, this chapter now explores views on CHWs services for sexual violence collected through in-depth interviews with survivors, CHWs, professional healthcare providers and other stakeholders. The aim of this chapter is to explore the experiences of these different stakeholders with CHWs, identify current CHWs roles in sexual violence and potential areas where CHWs' interventions can address the barriers to treatment. Participants were asked about their views on what roles CHWs played in sexual violence services and what other potential roles they could take up along survivors' pathways of healthcare. Survivor perceptions were an indicator of acceptability of CHWs to survivors. Community health workers' feelings were a pointer to their self-efficacy and motivation in providing such services. Professional healthcare providers and other stakeholders' attitudes towards CHWs and their ability to deliver such services were an indicator towards the feasibility of integrating such services within the existing framework of care. The participants also described the challenges that might be experienced through provision of such services as well as the potential benefits that would accrue from using CHWs to provide services to sexual violence survivors.

7.2 Methods

The study design, study location, development of tools, ethical issues, data collection and analysis are described in detail in the methodology chapter (chapter 3). The topic guide for the different categories of interviewees are provided in Appendix 2-6. This section therefore only focuses on the selection of the different participants.

7.2.1 Selection of sexual violence survivors

The selection, recruitment and interview process for survivors is described in chapter 6. All the survivors interviewed on pathways of healthcare were also interviewed on CHWs

services. For this component of the study, survivors were asked about their awareness of CHWs; the CHWs' roles; their willingness to use CHWs' services and their perceptions of the benefits of CHWs services.

7.2.2 Selection of community health workers

Community health workers were selected differently in the two sites. In Naivasha Sub-county Hospital, CHWs were selected through the nurse counsellor who identified CHWs who had been escorting survivors to the hospital or who had taken part in other non-GBV related hospital activities. She then contacted these CHWs and invited them to come and talk to me. On the appointment day, the nurse counsellor introduced the CHWs and I went through the informed consent process with them. In contrast, in Thika Level 5 Hospital, staff attending to survivors had little formal contact with CHWs. So for this facility, I used the community health extension worker (CHEW) to identify CHWs to interview. The CHEW is based at the hospital in the District Medical Officer of Health's offices and is in-charge of supervising the CHWs' attached to this hospital. The CHEW organised a group meeting for me to meet the CHWs. During this meeting, I explained my study to the CHWs and invited them to participate. I then scheduled individual interview time with each CHW where I explained the study in more detail and took informed consent. CHWs were included only if they had been engaged as a CHW for at least 3 months.

7.2.3 Selection of professional healthcare workers

Professional healthcare workers were selected purposively in the two facilities. I selected healthcare workers who provided services directly to the survivors and who had the maximum contact with survivors while they were at the facility. Full description of the selection process is provided in chapter 5.

7.2.4 Selection of stakeholders

For this group of interviewees, I first purposively identified organisations providing sexual violence services. I then contacted the person in-charge of SGBV or CHWs in that

organisation through a phone call or email. During this first contact, I provided information on my study and my study objectives. I then requested for appropriate key informants based on SGBV experience and CHWs services. The person in-charge then sent an introductory email to the potential interviewee informing the individual that I would be contacting them with the intention of interviewing them. Once I received the introductory email, I then contacted the potential interviewee, either by phone or email, explained the purpose of my study, determined suitability for participation and if suitable, requested them to participate. Once they agreed, we then scheduled a meeting where I consented and interviewed them. Informal discussions were also held with participants recommended either by those interviewed or other stakeholders (snowball). Participants for key informant interviews were drawn from an international NGO, a local NGO and the government. Similarly, informal discussions were held with participants from two local NGOs, an international NGO, the government and the two health facilities.

7.3 Findings

The findings are presented in four parts. Firstly, the characteristics of all the participants are described. Secondly, survivors' views and experiences with CHWs are presented. Thirdly, CHWs views and experiences with both general community health work and sexual violence services are described. Finally, views of HCPs and other stakeholders on CHWs' services for sexual violence are outlined.

7.3.1 Characteristics of participants

The characteristics of interviewed participants are summarised in table 7.1.

7.3.1.1 Survivors

The socio-demographic characteristics of survivors are described in detail in chapter 6. In brief, they were all female, half were single, more than half had a secondary education or above and nearly one third had not sought treatment for sexual violence. The majority were aware of CHWs, a significant proportion had received services from a CHW and most of those who had not were willing to use CHWs' services.

7.3.1.2 Community health workers

Both male and female participants were interviewed, with the majority being female (13 of 16 CHWs interviewed). All had between three and 14 years of experience as CHWs. Their education ranged from primary level to college education. All the CHWs except one had received the government induction training for CHWs but the duration of training varied significantly from five days to two weeks. This duration indicates that the majority of the CHWs had not completed the basic training modules as stipulated by the government. Some CHWs had additional training provided by NGOs for specific conditions: four in TB and HIV; three in maternal and child health; one in counseling; four in GBV; two were peer HIV workers; and one was a children's officer. It was not possible to obtain the training manuals used by the NGOs to provide this training. The training varied with location depending on the NGO involved, for instance, all those trained in TB and HIV were from Thika Level 5 Hospital while those trained in GBV were all from Naivasha Sub-county Hospital.

There were other notable differences between CHWs from Naivasha Sub-county Hospital and CHWs from Thika Level 5 Hospital: while all the CHWs in Naivasha Sub-county Hospital were female, a third of the CHWs in Thika Level 5 Hospital were male; half of the CHWs from Naivasha Sub-county Hospital had a secondary education and the other half a college education while nearly half of CHWs from Thika Level 5 Hospital had primary education only and none had a college education; CHWs were generally younger in Naivasha Sub-county Hospital (35-50 years) while more than half the CHWs in Thika Level 5 Hospital were 50 years and above (38-66 years).

7.3.1.3 HCPs and stakeholders

Among the six professional healthcare providers interviewed, two were trauma counsellors, two clinical officers and two nurses. The mean age was 40 years. Both gender were interviewed and they had all served for more than one year in their current position. Similarly, stakeholders interviewed both formally and through informal talks were both male and female. Their roles varied and included GBV technical officers and researchers, hospital and departmental heads and ministry of health officials.

Chapter 7: The role of CHWs in sexual violence services

Table 7.1: Characteristics of interviewed sexual violence survivors, CHWs, HCPs and stakeholders

	Characteristic	Frequency
Sexual violence survivors (n=24)		
Age	Mean (range)	29 (18-43)
Marital status	Single	12
	Married	7
	Separated/divorced/widowed	5
Education	None	1
	Primary	9
	Secondary	11
	Tertiary	3
Sought treatment for sexual violence	Yes	17
	No	7
Experience with and willingness to receive sexual violence services from CHWs	Have never heard of CHWs	9
	Have received sexual violence services from a CHW	9
	Have not received sexual violence services but willing to*	14
	Would use services from a CHW but not one from her community	4
	Would never disclose violence to a CHW	2
Community health workers (n=16)		
Age (years)	Mean (Range)	49.2 (35-66)
Gender	Female	13
	Male	3
Education	Primary	4
	Secondary	9
	College	3
Marital status	Single	1
	Married	9
	Separated/widowed	6
Years of service	3 years	4
	4-10 years	8
	> 10 years	3
	Duration not given	1
Professional healthcare providers (n=6)		
Age (years)	Mean (Range)	39.7 (26-56)
Gender	Female	5
	Male	1
Profession	Nurse	2
	CO	2
	Trauma counsellor	2
Stakeholders (n=15)		
Type of organization & occupation	Local NGO (GBV technical officer)	1
	International NGO (Researcher)	1
	Government (CHEW)	1
Informal talks	Various roles and organisations	12

*Includes those who had previously not heard of CHWs but willing to on description of what CHWs do.

Abbreviations: CHEW- Community Health Extension Worker; CHW- Community Health Worker; CO- Clinical Officer; GBV- Gender Based Violence; NGO- Non Governmental Organisation

7.3.2 Survivor experiences with and perceptions on CHWs

This section presents past experiences of survivors with CHWs services and their attitudes towards these services. The findings show that survivors were aware of CHWs and their

roles in the community but the majority had not received services from CHWs. However, they were willing to receive services from CHWs and thought CHWs services would be beneficial in providing information, referral and accompaniment to services, and psychosocial support. The main strengths of CHWs services were in their accessibility and flexibility.

7.3.2.1 Awareness of CHWs

The majority of the survivors interviewed were aware of the existence of CHWs and the types of services they offered. Survivors noted that CHWs visited households and worked in the community on various health-related issues. Survivors reported a wide range of roles carried out by CHWs in the community (figure 7.1).

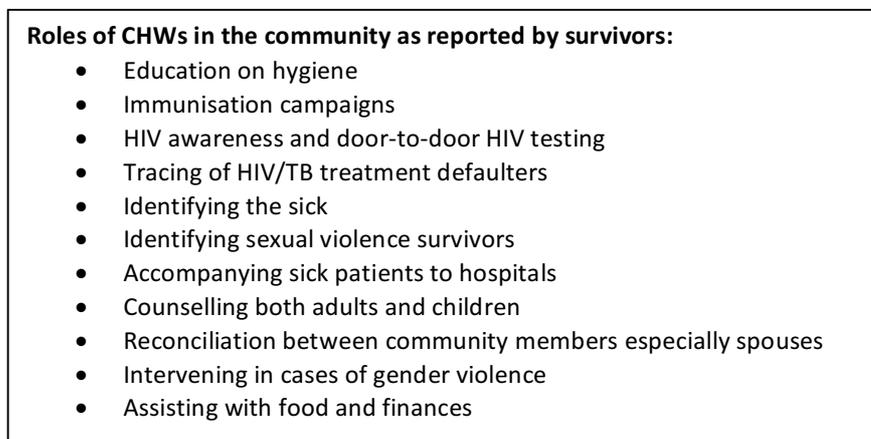


Figure 7.1: Roles played by CHWs as reported by survivors of sexual violence

About a third of the survivors had received support for sexual violence from a CHW. The support received included counselling; advice on available services and social issues; being taken to the hospital by the CHW; being accompanied to report to the police; being invited to a support group; being taught income-generating skills; and, material support such as food or cash. All the survivors who had received a CHW's support for sexual violence had not accessed hospital services for the violence prior to meeting the CHW. All except one were beyond the recommended period for any treatment other than psychosocial support and management of complications such as HIV.

It is worth noting here that nearly all of the survivors (8 of 9) who had received CHWs' support for sexual violence did so from one female CHW and were recruited through the WKF, an NGO that supports survivors at the community level. Although many of them

knew other CHWs in their community, their experiences with CHWs were primarily with this particular CHW. The majority of the survivors recruited from the two hospitals had no experience of receiving services from CHWs for sexual violence. Most of them however were aware of CHWs and their roles in the community and indicated a willingness to receive services from CHWs.

There were differing ways in which survivors who had received support from CHWs first became aware of and engaged with one. In most instances, the first contact was through a chance meeting followed by a deliberate effort from the survivor to talk to the CHW. Attending awareness talks in the community facilitated by the CHW was among the main routes that survivors mentioned. The talks often happened or were announced at social gatherings such as religious functions. Hearing the CHW providing information on sexual violence during these talks often resulted in a survivor seeking out the CHW later and sharing their situation with her as this survivor explains:

“I had just gone to the Chief’s camp to check on something else. I heard her talking to some other women. I called her aside and told her there is something I would like to talk to her about and requested her to come to my house so I could tell her. She asked me where I lived and later she came.” (Survivor, WSV02)

The fact that the CHW easily shared her contact details during health talks also enabled survivors who were not present at these talks to engage with her. Those present at these meetings would share knowledge gained and contact information with others in the community. For instance, one survivor reported that she heard about the CHW from her daughter who had attended a health talk facilitated by the CHW at her school. The survivor obtained the contact details from her daughter and contacted the CHW. Friends who were already familiar with the CHW’s job and felt a survivor would benefit from the CHW’s assistance also introduced other survivors directly to the CHW.

The type of chance meeting mentioned above and the subsequent development into supportive relationships was common. This highlighted many survivors’ need to talk to somebody about their violence experience and their struggle to find a trustworthy person they could talk to. Survivors reported that getting the confidence to disclose their

experience involved many meetings and time spent together with the CHW, something that some observed was not possible with professional healthcare workers. For some survivors, the CHW was the first person they were disclosing to and their only source of continuous psychosocial support.

“The only person I have told is [name of CHW] and I came to know her through my daughter who is now in form four. She was in class 8 then, there is a day [name of CHW] went to their school in [name of school] to talk to them about rape, what you can do, where to go for treatment, things like that. So when my daughter came she told me, mom today we had a good discussion with a social worker she told us many things about rape, she gave us the numbers you can call if you are raped, she told us if you are raped, don’t bath, go to the hospital, such things. I got interested, I didn’t tell my daughter, it’s like the way somebody can tell you something which helps you, so I asked her, did she give you her telephone number? She told me, mom here it is. I told her let me keep it, it might also help me, I did not show her any interest. The next day I called [name of CHW] and told her I would like to talk to her as I had a similar issue [rape] and had been wanting to talk to somebody. I directed her to my house and she came.” (Survivor, WSV04)

7.3.2.2 Willingness of survivors to receive services from CHWs

Although not all the survivors had interacted with a CHW before, nearly all survivors interviewed said they would be willing to speak to a CHW about their experience. However, certain preferred characteristics in CHWs were noted by both those who had and had not received services from CHWs. In particular, trust and ability to keep confidentiality were a prerequisite for survivors to speak to a CHW. Survivors gave examples of CHWs who did not keep patient information confidential and they therefore could not approach them for help. Survivors who were using the CHW stated they had first taken time to establish that the CHW was trustworthy and could be trusted to keep information confidential. This often involved building a relationship over time with multiple meetings before the survivor felt comfortable enough to disclose her experience of sexual violence. The close proximity of the CHW living within the same community enabled this kind of relationship to develop.

“I did not tell her [CHW] what it was the first time. You know, you must first observe the person and understand them. I asked her questions indirectly first over time and eventually I opened up and told her [about the sexual violence].” (Survivor, WSV02)

Survivors also highlighted the importance of training and empowering CHWs as a key requirement. Noting that CHWs are limited in the range of services they can provide, it was suggested that only when CHWs are well trained should they be allowed to provide even those limited services as illustrated by this survivor:

“Before they [CHWs] are released in the community, they must know how to handle people, they need to be trained and have accurate information. Because, some of them also act as if they are doctors, they will even bring you medicine. Like one of them used to go and buy medicine even if it is just paracetamol and then she brings it to you when she doesn’t know what you are suffering from [...]. So they should be well trained so that they can do what they are able to, like check how a patient is taking her medicine but not to treat.” (Survivor, WSV05)

Several survivors who had not disclosed their abuse to a CHW expressed the view they would feel more comfortable receiving services from a CHW who does not reside within their own community. Those who held this view feared that a CHW from their community might disclose their situation to other community members.

“I cannot [talk to a CHW from her area] because there are some people you talk to then they tell the whole village. Or she will tell her friend, and her friend will tell another friend [...]. If it is someone from another area, I can tell them because if you tell them your story and she lives away, she cannot tell people from her village.” (Survivor, NSV07)

This need for confidentiality was also emphasised by survivors who had received services from a CHW. However, survivors who had received CHWs services pointed out that the CHW’s personality and her/his ability to keep information confidential was more important than where they come from, noting that they had contact with different CHWs but were able to confide in one but not the others.

“You know also, you cannot tell all of them [tell all CHWs about violence]. There is something called confidentiality, she [a particular CHW] knows how to keep confidentiality. There are other CHWs I know, but she is the only one I can share with.” (Survivor, WSV04)

7.3.2.3 Perceived roles of CHWs in sexual violence services

Psychosocial support: The main role of CHWs mentioned by survivors was advisory. Survivors observed that the CHW encouraged, counselled and advised them on what to do in regards to the violence and also in other social issues. As such, the CHW was not only a valued ally in care seeking but also a confidant in other personal matters. Having someone who could be available to listen to them and provide encouragement as well as link them to professional support when they needed it was highly appreciated by survivors. All the survivors who had support from the CHW observed that they had improved markedly as a result of this support. The range of support and the resultant benefit were clearly illustrated by one survivor who said of her association with the CHW:

“She is the one who has been encouraging me; at times bringing me over here at [name of regional hospital] to the counsellors, then they talk to me [...]. At times she is the one who looks for me, or at times I could just be in the house just thinking, I just feel I want to call her. Then we just communicate through [...]. I find it better because I was worse; I had lost weight completely. I used to be engulfed in thoughts and tears just rolling down. But currently even people have been wondering what I am eating of late; because through the support I receive, I can see good things happening and my heart easing up.” (Survivor, WSV01)

Referral and accompaniment to services: As indicated by the above survivor, referral was another role that the CHW undertook. The CHW advised survivors to seek initial healthcare and also continuously encouraged survivors to go for professional counselling when needed. The CHW also played an accompanying role to the survivors escorting them to hospital and to other services such as police.

Organising support group and linking survivors: The CHW organised peer support groups that were reported as very helpful. These groups helped the survivors interact with people going through similar experiences and were also used as income generating forums where survivors learnt different activities such as knitting and making soap that they could then sell.

“So when [name of CHW] has organised a group meeting, she calls me. But they [other survivors] are not from my area [...]. So we share our experiences. At least it helps me because before I was just silent on my own. I used to feel bad but I didn’t know whom I could tell.” (Survivor, WSV02)

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Because many survivors in the community did not disclose violence, it was difficult for survivors to get to know each other. This lack of contact with other survivors prior to joining the support group was common among all the survivors. However, with the support groups organised by the CHW, they were able to meet other survivors. As the above survivor indicates, the CHW was able to bring survivors together even when they did not belong to the same locality.

Education and awareness creation in the community: The CHW provided education to individual survivors on what to do. She also educated community members on sexual violence through group meetings, public talks and school outreaches. This helped create awareness in the community on the problem of sexual violence and on services available.

Note: Survivors recruited from the hospitals had little experience receiving services from CHWs. It is possible that this group had little contact with CHWs because it was a significantly small proportion of all the survivors attended to at the hospitals: other survivors who were not interviewed may have had services from CHWs. It is also possible that these survivors had not received sexual violence support from CHWs because their incidence of violence was much more recent compared to those survivors recruited through the NGO. In addition, there was no evidence of CHWs actively seeking out survivors in these two areas.

Despite this lack of experience with CHWs, they identified potential areas where they could use CHWs services. Follow up was mentioned by several survivors with one survivor specifically pointing out that such a service would have been very useful in dealing with the everyday issues such as treatment side effects.

“Yeah, actually sometimes like in that period, the medicines were not exactly going well with me. You know, sometimes you have to, you can’t eat something and you feel like you have to puke. So if there were someone [CHW], I think it would be nice. Someone you can talk to about the drugs. Because you cannot always come to the hospital every morning, every evening.” (Survivor, NSV02)

Her view mirrors that expressed by survivors who had used CHWs that CHWs are more available and flexible compared to HCPs. In addition to support through treatment the survivors who had not received services from CHWs mentioned providing education within the community and advice to individual survivors as potential CHWs' roles: *"To support me by telling me where am supposed to go when I get that incidence (rape)."* (Survivor, NSV06)

7.3.2.4 Advantages of CHWs in sexual violence services

Easy accessibility and flexibility: The biggest advantage of having the CHW was her easy accessibility and flexibility. Survivors reported that they could call the CHW anytime they had a problem. They could also go to her or they could request her to come to their home. This was valued as it was easy to schedule a time that was suitable to both the CHW and survivor due to their proximity. In addition, survivors were not afraid of the CHW as she was viewed more as a friend than a professional healthcare worker. It was also evident that once they trusted the CHW, they could share intimate details about their life without fearing that the CHW will talk about them as illustrated by this survivor:

"They are a very near helper because it is someone from your community, so you don't fear facing them as opposed to facing someone from far whom you don't understand [...]. In fact, this is a very important person because they come to check on you even in your house but a doctor you leave them in the hospital. This one follows you up, and if you call them at any time, they are available [...]. They are very friendly, you are with them in the village, you meet. Unless, a CHW likes to talk about people [then you would be afraid of disclosing to them] but most of them don't talk. If you tell them things about yourself, they just keep them to themselves. Like [name of CHW], if she was to talk about me when I was very sick? Nobody knew about it [meaning the CHW knew about her sickness i.e. HIV but never told anyone] [...]. Even food, sometimes you tell [name of CHW] I don't have, she brings me flour or she gives me 100 shillings." (Survivor, WSV05)

Feeling of kinship: The kind of support described above was only possible because the CHW being a member of their community understood them and what they were going through and was therefore able to give appropriate advice and assistance. This was particularly relevant as survivors felt that while an outsider may be able to help with healthcare needs, he/she may not understand the social and personal circumstances of the survivor. As the above survivor illustrates, there were instances where the CHW had

in addition to helping them get medical and psychological care had also assisted with basic needs such as food, something they felt an outsider may not understand or they may not be able to tell an outsider they had no food. While this ability to assist in all aspects was appreciated by survivors, it points to extremely high expectations placed upon the CHW. Some of these expectations were well beyond their mandate for instance assisting with food and finances. These types of expectations could potentially have a negative impact on the healthcare relationship if CHWs are unable to meet them.

All-encompassing support: As can be noted from the descriptions of survivors above, the CHW led to improvement in multiple areas of the survivors life including physically, psychosocial well-being and financially. These areas were interlinked and improvement in one led to improvement in the others. Psychologically, the CHW provided counselling and also linked survivors who needed further counselling to hospitals. Socially, the CHW became a friend who could easily be reached and also introduced survivors to other survivors. Also, due to the psychological well-being, survivors could relate better with others. Once survivors improved psychologically, they were better able to take care of themselves and improved physically. They were also referred for treatment of physical illnesses. Financially, once survivors became physically and psychologically better, they were able to work. In addition, the CHW introduced them to income generating activities.

7.3.3 CHWs views of their roles in sexual violence services and barriers to services

This section presents CHWs views of their roles in general healthcare, their current and potential roles in sexual violence services as well as individual-, service- and community-level barriers to these services. Notable differences between the perceptions of CHWs in the two hospitals are highlighted.

7.3.3.1 CHWs current roles in general healthcare

To start off, it was important to understand the current roles and responsibilities of CHWs not only in sexual violence but also healthcare in general. This is an indicator to both their capacity to perform certain tasks and the burden of adding more roles to their existing workload.

Community health workers mentioned multiple roles that they undertook within the community. Although these roles were not uniform among all CHWs, some were common among nearly all the CHWs. One such common role was in regards to being the local resource or contact person for the community in matters related to health. Commonly used phrases in regards to activities related to this role included 'identifying', 'advising', 'directing', 'teaching', 'training', 'referring', 'policing', 'advocating' and 'leading' in various health issues. Community health workers visited households, identified health and social problems in these households, gave advice on how to deal with them or referred accordingly. Among problems identified and dealt with were in relation to hygiene, nutrition, safe motherhood, communicable diseases (HIV, TB, diarrhoeal diseases) and safer sex practices. In addition, they played key roles in creating awareness in the community and carrying out disease prevention activities such as immunisation, education on HIV testing and condom use, cancer screening, malaria prevention and deworming.

"Mostly what I do is concerned with the village, I check how the village is and then report what I find. Like let us say for example there is a time there was an outbreak of cholera, we report to the public health so they can act, and there was a time we had bedbugs and we reported [...]. The work of a CHW is a lot because, you must make sure the area where you have been selected or you represent is clean. You go to every homestead and teach, we were each given 20 households but the way houses are built here, they are too close together so they are too many." (CHW, TC01)

"I am a community health worker from [name of place] whereby I do identify the cases like sexual harassment, sexual violence, and home-based violence. Also identifying HIV cases. I also test TB cases and I also work with the youth in the village where I unite them together into social sub-groups and I also work with partners that come on board. I also work with the orphans, children between a day to 18 years under K-NOTE of APHIA-PLUS. Then I also work with partners, they normally take children of 18 years to 25 years and take them for vocational trainings and I'm their mentor in the community. And I also serve God, I also attend churches [...] I also improve hygiene in ECD (Early Child Development) centres by introducing hand washing program." (CHW, NC04)

As the CHW above (NC04) alludes, in performing their tasks, CHWs dealt with community members from all age groups including children, youths, adults and the elderly. The services they offered tended to differ by age group depending on the stage of life and pressing issues at that stage. Among children, the main activities were related to growth monitoring, nutritional advice, deworming, immunisation and education. Among the youth and adolescents, CHWs addressed issues of puberty, substance use, sexual health, social behaviour and training. Among women, issues addressed included pregnancy, contraception, relationships and child care while in the elderly food and nutrition, age-related health conditions, neglect and loneliness were the main issues. Within relationships, CHWs frequently mentioned gender-based violence as one of the issues they had to deal with.

CHW: *Mostly I visit the houses of these young couples and the old people, and the vulnerable.*

Interviewer: *Ok. Why do you prioritise the young couples?*

CHW: *The young couples because of the children. They are at the child-rearing stage. And most of them don't have the information on how to rear the children health-wise, such things. And also concerning the domestic violence, they are the same houses that have such cases.*

Interviewer: *Ok. And the older ones?*

CHW: *The older ones, they are vulnerable to diseases, they have been neglected. Some of them are caring for grandchildren that their children have left behind. (CHW, NC04)*

“Well for the orphans and vulnerable children, and mostly the orphans, each of them have their stories back from the time they lost both parents or one. So that is the first step, I listen to their stories and then from there, the life they have. Some you find they are so hopeless, so all they need is someone to confirm to them that life is not like that or it can change from the current situation. And then we link them where they can find help [...]. Also the youths most of them dropped out of school or went up to class eight or form four but didn't go on. They want to do a course, they want to start their businesses, so I link them where they can get the support either to start a business or the vocational training. Now the elderly, there are those that do not even get out of the house, so I find them, they have no one to talk to, so I create my own time to go talk to them. There are those that need the

basic needs like clothes, food, some even need some medicine. There are also some people who deal with the elderly, so I also link them.” (CHW, NC06)

Some cases and conditions were more challenging to handle than others. Sexual and gender-based violence were frequently mentioned as a difficult issue to deal with due to several reasons: CHWs had limited training on how to handle it; it often involved many people including family members, local administration and the police; and, it posed a threat to the personal safety of CHWs.

“Like the other day I got a case where a husband was beating his wife in a locked house. Community members called me. So, mine is to call the police to intervene, so they came. But you find sometimes you call them they tell you there is no vehicle, there is no fuel. Me as a community social worker am not supposed to pay anything because I don’t have that money. So, I just leave the case like that. And that husband will continue beating his wife and he will think you are a useless person [meaning CHW cannot do anything to stop him]. So those are the challenges that we find in the community.” (CHW, NC02)

“The other case is when a child is beaten by parents who are fighting each other. At our place we have village elders, the village elders ask for money in order to call those people. Before that ends you see you have gone to report and you are being asked for money, you go to the police about raping, or fighting children especially, they ask for money and you have not been given money for that job [...]. Mostly it is children and when you take that child to hospital, if it is for the police they want to be bribed.” (CHW, TC02)

The roles described by the CHWs generally tally with those roles mentioned by the survivors. The roles also did not appear to differ significantly between individual CHWs or the two groups of CHWs from Naivasha Sub-county Hospital and Thika Level 5 Hospital. Some of the roles however were well beyond the mandate of CHWs. For instance, a significant proportion of CHWs reported that they were involved in formal education of children within their community and vocational training for the youth. They also played a big role in linking the children and youth to organisations supporting education and adults to other service providers in the community depending on individual needs. These linkage roles often went beyond the realms of healthcare reinforcing the survivors’ reports that

CHWs had closer and more personal involvement in individuals' lives than what was possible with professional HCPs.

7.3.3.2 CHWs views of their current involvement in sexual violence services

It was evident from the CHWs' responses that they had no clear understanding of what their responsibilities were in regards to sexual violence. Almost all those interviewed in both facilities reported that they had not been given any training on sexual violence and had not been asked to carry out any specific activities towards this. The few (from Naivasha Sub-county Hospital only) who reported any training in SGBV received the training from different NGOs. The contents of the training and duration were not clear.

Nevertheless, all the CHWs had heard about sexual violence cases in their community and nearly all had personally handled at least one sexual violence case. Both groups of CHWs reported generally similar awareness of sexual violence and similar roles played. Those who reported having dealt with survivors reported varying levels of involvement ranging from assisting from a distance- with for instance information on where to get services- to physically accompanying the survivors through the various services. Community health workers from Naivasha Sub-county Hospital appeared to have more personal involvement with survivors and closer linkages with the hospital, often reporting accompanying survivors to the hospital and other services. In contrast, CHWs in Thika Level 5 Hospital more often reported providing information and referring survivors.

CHWs viewed their services as an integral role to the management of survivors. They emphasized their role in responding to the crisis at the community level, resolving family issues, advising the survivor on seeking both medical care and justice and escorting them to different services. They also reported that other people in the community and other service providers recognised the important role that they played and often passed cases of sexual violence to them.

"The other one [another sexually abused child] is from [name of place]. When I was going to work for that of [name of another place], the policeman saw me, he told the OCS (Officer Commanding Station), "Mr OCS, let us give this case to [CHW's name], she is the one who knows how to handle these cases." So I was also given the case." (CHW, NC01)

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While this referral to CHWs indicates that the CHWs were recognised as sexual violence services providers, it may also reflect that other stakeholders such as the police lacked the knowledge and skills to handle survivors and therefore passed them along to CHWs.

In dealing with sexual violence, a few CHWs reported that they often prioritised sexual violence as they thought it was a serious issue and found it much more involving and difficult to deal with. They reported that while in other cases they could refer the client to the hospital, in sexual violence they did not refer but instead accompanied the survivor along the whole breadth of care. One CHW explained that she did this because most survivors did not know what to do and were unaware that the services were available and free. While this accompaniment is a positive thing, the level of engagement described at times was very extensive to the point where CHWs appeared to make the decisions rather than the survivor or caregiver. Thus, in such a situation, it is possible for CHWs to 'take over' the case offering solutions to survivors rather than listening to their needs.

"The mother was around, so immediately I took the girl [to the hospital]. I left her mother in the police station. Because of the transport, because it is a family which is not able [to afford fare], so I left her mother at the police station." (CHW, NC01)

As earlier mentioned, this close involvement with survivors was more common among CHWs in Naivasha Sub-county Hospital than Thika Level 5 Hospital. Most CHWs in Thika Level 5 Hospital appeared to be more cautious about being conspicuously involved in the cases due to fear for personal safety.

"Even if the case [of rape] is brought to you and you are doing the follow up then you are at a dangerous place. You get involved while maintaining some distance, you talk from afar using your phone, I do the work using my phone. If it is the doctor treating the survivor, I talk to the doctor using the phone. If it is the police, I talk to them on the phone, then I give them everything [meaning information]." (CHW, TC02)

While this fear for personal safety was reported by both CHWs in Naivasha Sub-county Hospital and Thika Level 5 Hospital, actual physical assault of a CHW was only reported in Naivasha Sub-county Hospital. This may perhaps reflect the different levels of involvement observed in the two hospitals. Moreover, it is an indicator that CHWS

dealing with cases of sexual violence need training to be able to judge where their assistance is needed and where they may be taking over or their safety may be at risk.

Notably, even among CHWs in Thika Level 5 Hospital, the male CHWs were more likely to report less involvement with survivors compared to the females and to have misinformation about sexual violence. One reported that one time he was informed about a case of sexual violence and he asked the informer “to go find out more and then report to me” and did not follow up even after the informer failed to come back. The second one expressed reluctance to deal with survivors on his own reporting he had asked a colleague to accompany him to talk to a survivor; and the third displayed a high level of misinformation and misconceptions about what sexual violence means.

“As I can classify it [sexual violence], it can be raping, sodomising, lesbianism and this one called gays. And within the community of course we can’t deny that it doesn’t happen, it really happens. And I have never understood the cause that makes somebody, a grown up person that is a man to rape a very little girl [...]. And this other one, lesbianism that one comes with pornography. And it’s still a threat and there is another thing in secondary school they call it vibrator, have you ever heard of it?” (CHW, TC08)

Nevertheless, as only three male CHWs were interviewed, these observations should be interpreted with caution. It is also worth noting that interviewed survivors who reported willingness to receive services from CHWs did not indicate a preference for either male or female CHWs. Although survivors were not questioned directly on whether they had any preference between male and female CHWs, it was expected that they would have brought this up if they felt strongly about it: similar to other characteristics for instance where a CHW resided and trustworthiness of the CHW. Nevertheless, gender preference as well as preference for other individual CHWs’ characteristics is an area that is worth exploring further.

Community health workers reported various ways in which they came to interact with sexual violence survivors. These differed among child and adult survivors. Adults rarely came straight up to CHWs to ask for assistance. Instead CHWs heard about these cases from community members and found ways of approaching the survivor to offer help. In most instances, they reported that they approached the survivor indirectly. Some

preferred to talk indirectly to a group where a survivor was present and give general advice on what to do when one has experienced sexual violence. Often this survivor would then get the courage to approach the CHW for help. Others would visit the survivor and talk about sexual violence among other health related issues. When approached this way, survivors would then disclose to the CHW about their experience of violence and the CHW would give advice to the survivor on what to do and provide psychosocial support.

In cases of child sexual abuse, the initial contact varied. On occasions, CHWs came across children who had been sexually assaulted during their routine activities in the community. The most common way they came to know about them however is through being alerted by relatives, neighbours, teachers, chiefs and the police. The CHWs explained that because community members knew them and the work they were involved in, they would report to them if a child were abused. Educating teachers in schools about sexual violence also helped the teachers identify children with signs of abuse and contact CHWs to intervene.

“The mother takes alcohol so at times she goes and leaves the children alone. The children get hungry, there was a child who was being carried. So they would go somewhere in a café and another young man would give them food, like beans, chapo [a form of flat bread] and soup. We noted later that this child was being used [meaning sexually abused] by that man [...]. Someone came and told me. You know as a community volunteer, when people learn that you can keep secrets, they tell you things.” (CHW, TC04)

“The most recent rape case is one of a child in school which I learnt from the school. There is a teacher, actually one of the teachers called me and told me, “I can see the girl has a problem, and you taught us. The girl is not talking to us, she keeps crying in class, we see as if there is a problem”. And when we intervened the girl told us daddy put something [in her private parts].” (CHW, NC02)

7.3.3.3 Barriers to CHW services as reported by CHWs

There was a wide range of barriers reported that related to community health work in general and barriers specific to sexual violence services. These barriers were common among CHWs from both hospitals. General barriers were classified into three categories: individual-, services- and community level barriers. Individual level barriers reported were

workload and competing priorities secondary to financial needs. Services level barriers included lack of supervision, lack of recognition and support from other bodies. At the community level, barriers included community expectations and attitudes towards CHWs, traditional and cultural beliefs, poverty and structural challenges. Challenges more specific to sexual violence services were lack of training, lack of support from local administration and police as well as concerns for personal safety.

1. Individual level barriers

Workload: CHWs reported that the responsibilities they were given were often too much for them to fulfil adequately. In particular, the number of households they were expected to cover was too many and therefore the population served was too large. Although the community strategy in Kenya requires that one CHW serves 20 households, the CHWs interviewed reported that the area allocated to them comprised many more households, with most of them quoting 100 households or more. This was particularly so among CHWs living in slum areas and villages with high population density. Thus CHWs reported that they hardly had enough time to visit all these households.

“So you will find that where you were meant to have 20 households, in the actual sense they are 100 households. So it is hard to reach those people. You will find that in a month, you have visited about 40 households because you do not do this work from morning to evening, you do it part time because you are a volunteer.”
(CHW, TC01)

Financial needs: In addition to this huge number of households, they also had their own personal financial needs to attend to. The majority of those interviewed were unpaid. They therefore had to earn a living in other ways and often had to go to work or businesses during the day. Community work was thus limited to evenings and weekends. This limited time to provide services also meant that they were unlikely to manage the workload that they had. The lack of remuneration also led to some CHWs discontinuing their services thus increasing workload for those remaining.

“Again, the people that trained with me are not offering the service. They got tired because everybody needs money. And when you want to serve somebody well, you need to go to where they are, they will not come to you. They call you, they trust you. When they call you and you don’t go, they lose hope in you. So most of my

colleagues, the ones we were trained with, you call them they say “ah, you just go. Are we being given transport? [...]. They will tell you, I need to do my job.” (CHW, WC01)

“In the past, there was a routine, like we used to visit each household, but you see inflation has affected everyone. You know you are at your work and still you have a helping heart. So you look for some time when you are free to visit certain houses.” (CHW, NC04)

Even among the few who got an allowance, mainly from NGOs, the work burden was still huge as they not only had their normal CHW responsibilities, but in addition they had to perform specific tasks for the NGO paying them. The allowance paid was often limited (one CHW reported being paid 3000 Kenya shillings- the typical monthly pay for an unskilled worker is 7000 shillings) and they therefore still had to find other means of sustaining themselves. In addition some NGOs and individuals exploited the CHWs giving them responsibilities beyond their duties.

“It reached a point where you are paid 3000 by the NGO monthly and you agree with the doctor [private doctor working in collaboration with the NGO] on additional payments. So at times, the doctor would refuse to give you the additional. Or even if they agree, you will find that you are doing jobs related to his own clinic as you do the field ones so that he agrees to pay you. Now tell me, 5 women groups, 2 youth groups and between 100 and 150 households, household door to door campaigning for that thing [HIV and cancer screening for the NGO]. And you have to submit a report as well as the clinic’s report and then someone adds another job for you- cleaning the clinic, and making them tea so that they can pay your money. I realised I was being overworked and decided no, I stopped.” (CHW, TC04)

CHWs reported various ways they engaged themselves to earn a living. The majority were running small businesses in the community. Only one was formally employed. Other CHWs devised ingenious methods of both attending to the community and earning some income. One CHW talked of how she created work for herself by convincing the plot owners in her village to pay a small monthly fee to keep the village clean. From the proceeds, she employed herself and two other people to clean the village thus earning herself a monthly pay. Another one learnt how to make soap and as she visited households and schools giving health talks, she sold this soap to community members. A

third one started a school for children who were out of school. As she walked around the community, she convinced the parents of these children to send them to her school for free for those who couldn't pay and a minimal fee for those who could afford. With additional funds raised through well-wishers, she not only gets some income but also provides education for children who would otherwise not have gone to school. Another way used by most CHWs to earn some income was to attend any training offered or community committee meetings where attendance allowances were paid.

This need to earn a living while serving the community not only increases the workload but may also have counterproductive effects on the CHWs services. For instance, CHWs observed that members of the community were sometimes sceptical about their services being voluntary and unpaid. As such, CHWs may be perceived as having an ulterior motive rather than being there for patients thus affecting the ability of community members seeking services from them. Likewise, the activities that CHWs engaged in to earn money such as domestic services may compromise their authority to provide health services to some community members. This was well illustrated by one CHW who pointed out the contradiction where one day the CHW is in a household doing domestic chores such as washing clothes for pay and the next day she presents to give advice to the same person she was working for:

"I cannot say with 100% certainty [about CHWs' ability to carry out their duties] because I might be privileged because there are some other things I am doing [to earn money]. I am privileged I have a small business I am running; when I finish I go to do the community work. Another CHW might be a casual labourer. So these casual jobs, when will she finish washing clothes? Then the same woman washing clothes for you today, tomorrow she comes to your house to tell you about polio [meaning health talk on vaccination for polio]. You understand, and I like those women [CHWs] very much; I want you to understand how the community members view them. This woman who has been going round saying she has no cabbage [meaning the cheapest form of food], because I know them, is the same one who will come to dress your wound! How will that work? You see! There is a gap." (CHW, NC04)

2. Services level barriers

Lack of supervision: Many CHWs reported they had no formal links with the health system. Although ideally they were supposed to meet with the CHEW regularly, those meetings hardly ever took place and many CHWs did not know who their immediate supervisor was. This was surprisingly common even among the CHWs in Thika Level 5 Hospital who were selected through the CHEW, with only a few of them reporting knowing the CHEW. This is of particular concern as a CHEW is the immediate and only formal supervisor to CHWs.

Lack of recognition and support from other bodies: The study found that CHWs felt under-recognised both by the health system and the community. To start with, CHWs felt that professional healthcare providers, whom they were meant to work in conjunction with, did not recognise their role and often ignored their existence or suggestions. A few CHWs indicated that the hospital response to patients accompanied by a CHW was not prioritised. Thus, the CHWs were forced to spend time waiting for services with patients they accompanied instead of attending to other patients and their own personal issues. This made them reluctant to accompany patients to the hospital. Similarly, patients referred by CHWs were not attended to promptly. As such, CHWs' referral was not recognised and this resulted in a loss of respect from community members.

"They know us [HCPs] although sometimes they act as if they don't know us. Sometimes you take a patient and ideally I should not queue, because the work I am doing is voluntary, I am not being paid. So once the nurse or doctor sees me, it would be good of them to ask me, "What is the problem?" Or they call me aside, "is there a problem?" So when I go I will tell them I have this patient and they will let the patient come in (to be attended to). Or they let 3 people ahead of me to enter then I go in as the 4th person. So it forces you to stay there queuing until they are treated. So tell me, a rape patient has been kept that many hours, when you go to talk to them (HCP), they tell you to queue. And because we learnt they are not concerned, we go and queue or we leave the patient waiting, we just show them the rooms they will get into. Since you must also attend to your personal stuff." (CHW, TC01)

They also felt that other government bodies such as the local administration were not doing enough to support the CHWs and increase their visibility in the community. They suggested that simple things like being provided with an official badge for identification;

giving priority to patients they referred; being offered some recognition themselves when they presented for treatment by not having to queue or pay; and, being introduced to the public at community gatherings would help them gain recognition and authority within the community.

Lack of support was also mentioned in relation to provision of basic tools needed to perform some of their duties such gloves for home-based care. Likewise, lack of commodities such as medicines in local facilities hindered the extent to which they were able to assist patients.

“Another thing that hinders us is lack of medicine in the hospital. You take a patient to the hospital and there is no medicine, how do you help this person? They prescribe for you medicine to go buy, what will you buy with? You got this patient from the house to the hospital because he was weak and did not have anything [meaning money]. Medicine is prescribed for you to buy and you don’t have anything. You are taking them to hospital so that they can be helped and they can go back to their jobs. You go and medicine is prescribed, no medicine is given, you see that is another big problem.” (CHW, TC02)

3. Community level barriers

Community expectations and attitude towards CHWs: The views that some community members had and their behaviour towards CHWs were reported as a hindrance to effective service delivery. Being insulted and accused of taking advantage of community members for their personal gain was a common complaint. Some community members did not understand how CHWs could continually work as volunteers and therefore concluded that CHWs were using the needy in the community to get funds from donors and the government that they then used for themselves instead of passing it on to the needy. This demonstrates distrust towards CHWs genuine willingness to help. Such distrust may not only affect the willingness of community members to use the services provided by CHWs but also the motivation of CHWs to provide these services. One CHW summarised it thus:

“Sometimes you can go somewhere and someone offends you, like here where I live, if you dwell on how people view you, you can never help. You can even find someone calling you a dog, or you pass through a place and you hear, “eh, these days so and so has become very well kempt, it is because of the money they are

given to bring to us when they go to volunteer, they use it themselves”. (CHW, TC04)

In addition, the community had unreasonable expectations on CHWs. Many reported having encountered situations where community members expected them to be available at any given time or they expected CHWs to perform roles that did not fall under their job description, for instance, getting funding for school fees.

Beliefs about medical care: Cultural and traditional beliefs among some community members were a major hindrance to CHWs services. A few CHWs observed that certain members of the community were opposed to formal medical care. Traditions in certain tribes and religious beliefs were noted as some of the things that made people be unresponsive to CHW services.

“According to the Christian myth, some of them are religious and according to the religion, something they say, we don’t go to the hospital. Our belief does not rely on hospital, we rely on praying and requesting God [...]. There are others who will respond negatively especially in our area here. We have different tribes, and you see, in house number one and house number two and house number three there are all different tribes. And there are people who are after traditions very much. Like another one just about two weeks ago, she got a baby she doesn’t want the baby to be immunised against any disease.” (CHW, TC09)

Poverty: Poverty was also common in the areas served by the CHWs. This affected the ability of clients to access services particularly where a client needed to be referred to the hospital or to buy treatment. Because most people could not afford, CHWs were often forced to use their own funds or hold impromptu fundraising to help sick members of the community.

“You must set an example for them [other community members], you contribute first and then they will agree to contribute. You must tell them this person is seriously sick, I have contributed 100 shillings. You invite them to contribute to take the person to the hospital, they contribute. So you are forced to set an example, and it continues like that. Maybe for a month, you are contributing 100 shillings and you have no income.” (CHW, TC01)

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In addition, CHWs told of their discomfort visiting families who had no basic needs such as food and therefore CHWs had no option but to help. Given that they themselves were struggling as they had no regular pay, this was a particularly difficult position to be in. One CHW observed that in such a family, not only was food an issue, even giving basic advice on hygiene was a problem.

“Now to come to the point is that I do feel if I get a household they have no food, they have no basic needs, I have to look out for them. I have to help them. In some places you get that the household in which you are in, it is a single room. The children are there, kitchen is there, here there is a goat or sheep or a duck or a chicken. You see, in the same household. Okay, even if you want to tell them about hygiene, the hen the goat they will not...” (CHW, TC09)

“Sometimes you find others are drunkards, the mother is a drunkard. The children go to collect scrap metal, so this child is the one feeding the parent. Many women here go to look for laundry jobs in section 9 [an estate for middle class families] and in town. Sometimes, one may have gone to hustle but did not get anything. You find they are stressed, so you might knock and a child is sent to tell you that no one is in. You know that person is in but you just have to understand.” (CHW, TC01)

Structural challenges: Several CHWs observed that the nature of the settlements they lived in was another challenge. Because most of them were informal settlements, the population was very diverse and mobile. This provided a set of challenges for the CHWs: they had to keep introducing themselves to new people; there were multiple languages spoken; and, it was difficult to keep track of the community members as they constantly moved from one house to another. This made their work, especially continuity of education very challenging.

“You may find that the person you found in the homestead last week is not the one there now. Maybe a girl was living with a young man, you find they have separated and there is a new wife. So you must start educating, right? From the beginning and continue to where you can. Sometimes, the wife was beaten by her husband yesterday, she does not even want to talk to you. So you will be forced to counsel her first before you can educate her on anything. Counselling is usually very important here.” (CHW, TC01)

4. Barriers specific to sexual violence services

Lack of training: Lack of training was a challenge reported by the majority of the CHWs from both hospitals. Many of them felt the basic training program provided by the government during induction for CHWs was not adequate. Nearly all the CHWs had no training in sexual violence. For the few that had been trained on sexual violence, training was minimal and did not equip them fully to deal with sexual violence. The lack of training was evident in how CHWs dealt with sexual violence survivors. For instance, misinformation that could do more harm to survivors or delay survivors seeking care was observed.

“Sometimes they [other CHWs] deal with them in a non-professional way. The counselling maybe they are offering, they do not differentiate between counselling and advising. You find that mostly what they are doing is advising. And you know if you have a client you want to help move on, you are not supposed to advise them, you just help them to make their own decisions. Then you see they end up making decisions for them.” (CHW, NC06)

“Yes we were trained how to deal with such people. The ones who came to train us told us it is bad to hear a child has been defiled and not do something about it. First inform the chief then come with the police and go to hospital.” (CHW, TC06)

One CHW illustrated the difference that training can make by giving an example of how she handled two sexual violence cases: before training, she did not know how to handle a case and may have compromised forensic evidence; however, in a similar second case after training, she had the right information and knew what advice to give to the survivor:

“I remember there was a case and I was not trained, so what I did because I was not trained, I washed the girl and I brought the girl to the hospital because I didn't have any information. But after training, there was an incident where I talked to the parent, if it is a b c d, the defilement has been done, don't wash the girl lets go to the hospital and we got the information. It was very good and she was helped.” (CHW, NC02)

Training for CHWs involved in survivor care is paramount. As CHWs are lay persons, they are prone to the same misconceptions and biases prevalent at the community level. This may hinder survivors from seeking care and may also do more harm to those survivors

who seek care from CHWs. As these CHWs' views indicate, they can also be prone to not believing or to even blaming the survivor:

"To be frank, in my site, I've not dealt with the case of a woman who is saying that she has been done sexual harassment. Because you know the sex is part of life. Unless the people go to children [...]. And you see a grown up person or an adult some people even enjoy, you see. At the end of the day it has happened, but might be she also enjoyed the sex, you see [...]. Especially here the area we are, it is not possible for adult sexual harassment because of the side of security, you see, especially in town, unless somebody comes from a bar at night, but I see on the side of town, it is not, rarely." (CHW, NC01)

"There is another woman here who was raped while she was drunk. Such a person I will tell them to take alcohol as a woman or girl is not right. You will find that here you can be raped because you are not even helping yourself. You can scream for help but when you are drunk, you cannot. You tell them that alcohol is not good. And don't go near men when they are doing their own things even if they are practising karate because that is where thoughts of rape come up. You have to know how you will live. You need to know whom you will hang around with. Because even a Kikuyu saying says that when you are near a bad person then you will end up doing bad too. For example getting back home at nine o'clock in the night and you have parents who are warning you about your behaviour. Those are acts that you could have caused them yourself." (CHW, TC03)

Although there was a new training curriculum provided by the government as a standard nationally for all CHWs that included sexual violence, those interviewed had not received this training. While interviewees agreed on the need for further training, there was no clear consensus on who was currently charged with this responsibility. Previously, the central government provided the initial training. With a recent devolution of health services from the central government, it was not clear whether the local governments would take up this mandate. Moreover, it was reported that NGOs that had previously provided training and support for the CHWs had withdrawn their support either due to lack of funding or due to some other reasons.

Safety concerns: Fear for personal safety was a main concern in dealing with sexual violence. These concerns were mainly two-fold: firstly, as regards sexual violence (and

other forms of violence) in children, the main offenders were relatives. Often, family members defended the offender in order to protect the family's reputation or breadwinner. As such, they often became offensive towards CHWs following up such cases. One CHW told of how she was once slapped by a family member for following up a case of severe physical abuse to a child. In addition, family members subverted the course of justice when relatives were involved. Additionally, relatives of survivors also organised for a local settlement, with the perpetrator paying some money especially in cases of child sexual abuse.

Secondly, the other common perpetrators of sexual violence were known criminals who threatened anyone involved in their cases. There were instances where community members and CHWs had been attacked or their houses burnt because of getting in the way of the criminals. Due to this, CHWs avoided such cases and if they did help, they kept their involvement hidden.

"There are people who don't want their relatives to be jailed. He has done wrong but they don't want him to be jailed. Yes, if they have the money, "then mine won't be jailed", that is what people say." (CHW, TC04)

"It has happened to me personally, you are helping a survivor of defilement, you are doing your best, and you are trying to get this person to get justice. Then you are almost killed [...]. They came to my house, turned my house upside down, they almost killed me, I have a scar here. I stayed in the ward for some time. Because they were thinking I've been given money. This is a defilement case that happened sometimes back. The girl was 16, she was intellectually handicapped and she is defiled, she is pregnant. You need to help her. So what do you do first? Take her to hospital to confirm the pregnancy and whether she is sick, and then look for a shelter. So when I took her to the shelter, the mother- the perpetrators were three, they came talked with the mother [...]. The three perpetrators gave her 200,000 shillings. They told her to tell me to bring back her child." (CHW, WC01)

Lack of support from the police and local administration: The police and the chief were reported as being indifferent in most cases. At times they demanded to be paid before they could assist. With reference to sexual violence in particular, CHWs reported that they not only asked for bribes from survivors and CHWs so that they act to arrest the offender but that at times they took bribes from offenders so that they don't arrest them.

In that kind of environment, the CHWs were afraid to report sexual violence to the police or indeed any other offences fearing that the police may reveal their identity to the criminals. Instances of CHWs being harassed by the police over cases were also reported.

“Most of the chiefs are corrupt because when you report the case [defilement], they are supposed to be reported, but you see the chief comes behind your back to the family and tells them “let us resolve this issue” [meaning negotiate with perpetrator]. Being a community social worker, how will that family view you? If the chief can agree to do one two three, who are you to report us? So those are the main challenges we get. And you see that some of these things make even the CHW give up, they withdraw. You withdraw from that case of defilement because, even if the child was abused, the family and the chief have compromised. What are you supposed to do? [...]. And even the police, they hide the information. You find that you have reported a case to the police, so the next thing should be going to court, but you hear the case was not prosecuted [...]. And when the same person [perpetrator] comes back to the community, they know the person who reported the case is [name of CHW].” (CHW, NC02)

CHWs attitudes towards sexual violence: The study also found that a few of the CHWs had negative attitudes towards sexual violence survivors. This was not surprising given the normative community attitudes towards violence and the tendency to blame survivors. These negative attitudes could affect the type of care that CHWs can offer survivors. They also have the potential to cause further harm to survivors through re-victimisation.

7.3.3.4 Facilitators of CHWs services

Although as discussed above there were many barriers to CHWs' services identified, some factors that enhance the work of CHWs were also identified. These factors include the fact that CHWs are locally based and therefore easily accessible to the community, they know their communities well, are highly self-motivated and have many opportunities to network and assist each other making it possible for them to attend to a larger community than each single CHW is capable of. These factors are discussed further below.

Proximity and accessibility: Being close to the community where they offered services was one of the greatest advantage CHWs had. Due to this proximity, CHWs could

schedule their visits at their own convenience especially in the evening after finishing their personal businesses. In addition, if they failed to find the person they wanted to visit, they could easily plan a second visit or even meet that person during the normal day-to-day activities within the community. Clients need to work dictated when they would be available for CHWs. CHWs were flexible enough in their work and could schedule time when clients were available. Community members were also able to contact them at any time including late at night whenever an emergency arose.

“You understand that even if you don’t see her today, tomorrow you will find her. Or I might meet her at the water point fetching water and I will tell her, yesterday I was at your place I wanted to talk to you but did not find you. So she will ask me what I wanted. I tell her, I wanted to see you, I wanted us to learn a little. She asks me when will you come, so you go and educate her, you start for instance on hand washing.” (CHW, TC01)

“Like me I do work even past my time, at ten in the night, you find me in one of the households, because I target, my work is normally like that. I normally go to households now from five in the evening, after their work at least.” (CHW, NC05)

Local knowledge: As members of the community, they were privy to community knowledge that an outsider would not get. They knew the local language, the local customs, the norms of the community, their needs as well as their fears. In addition, they had developed rapport and build trust with members of the community who promptly informed them of any developments in the community. As already mentioned, CHWs for instance, were often informed about cases of violence by neighbours, relatives, local administration, teachers and even the police.

Self-motivation: Many CHWs had been helping community members long before they were formally selected as CHWs. As several stated, ‘helping was in their blood’. External sources of motivation for CHWs reported were limited. The opportunity to meet influential people was one such motivator. Although many CHWs felt that they did not get enough support from the government, the hospital, the police etc., a few indicated that being a CHW helped them get into contact with important people and organisations. One CHW said that as a CHW, she interacts with people in the health sector, police,

justice and other organisations. Such contacts had been important as some had assisted her in her personal issues. Another motivator for CHWs was the opportunity to be offered first priority whenever a health related training arose. Nonetheless, many CHWs reported that they received very little external motivation but rather drew strength from within themselves to continue helping the community. This drive to continue emanated from various intangible motivators that the CHWS referred to: “having the heart”, “the joy of seeing the community healthy”, “when the community is healthy, I am also healthy”, “being paid by God”, “passion” and “it is something in my blood”.

“I told you am just a volunteer, they don’t pay me but if there is something actually, sometimes they give me something little because of the airtime and other things like transport. So what I would like to share with you is that during the work that God has given us, because this is God given work, it is a passion, because if it is a person who has appointed me to do such job, I can’t do it. But now it’s an inborn in me to care for the community that I serve and that is why I said that dealing with adults, it is not that easy because sometimes you see that some are not accepting you.” (CHW, NC02)

Networking: Networking among CHWs was mentioned as one of the ways that helped CHWs cope with the many challenges they encountered particularly those that related to solving health related problems. Thus, CHWs said they often consulted each other in difficult cases.

“Because we have each other’s number (telephone), you call them and ask, I have this kind of case, how do I go about it?” (CHW, TC04)

Some of the CHWs noted that at times, they asked a fellow CHW to accompany them to visit a particularly difficult case. One male CHW explained that when he had to deal with an issue relating to a woman such as sexual violence, he would ask a fellow female CHW to accompany him. In addition, they took detailed information of clients (e.g. official name and name known at the community, physical landmarks of their home etc.) who needed regular follow up such as those on TB or HIV treatment. This information was important so that if the CHW following up the patient was unable to visit for any reason, they could ask another CHW to go visit on their behalf.

7.3.4 Professional healthcare providers and other stakeholders views of CHWs

This section focuses on the views on CHWs expressed by HCPs and other stakeholders involved in providing healthcare services for survivors of sexual violence. The HCPs and stakeholders recognised CHWs as viable partners in sexual violence care in certain roles such as creating awareness and providing follow up. However, they observed that for CHWs to be effective, issues such as training need to be addressed.

7.3.4.1 HCPs and stakeholders recognise and appreciate CHWs services

Professional healthcare providers and stakeholders recognised that CHWs played important roles in healthcare. These roles were particularly possible because CHWs are responsible and respected in their communities. The respect in most cases was regardless of their qualifications such as education background and this made it possible for them to be accepted by community members.

“When you hear community health worker, you know, the first impression you get is the typical community health workers who you know may not be very highly educated, but are respected in their communities, responsible and they are able to carry out certain tasks.” (Stakeholder, SH01 (International NGO Researcher))

The stakeholders and HCPs described various roles carried out by CHWs. These roles were similar to roles described by the CHWs themselves. The description of the HCPs and stakeholders on what the CHWs roles were further corroborates the magnitude of the workload that CHWs reported.

“Okay, they are expected to visit those households each month. Get the data on children who are underweight, children who are malnourished, and children who have not gone for immunisations. They are supposed to look after pregnant mothers who have not yet started their antenatal clinics, they are supposed to refer them as well. They are also supposed to ah, look whether the family is able to, has the staple foods that are supposed to be in the household. They are supposed also to record any deaths that happen within the communities, especially those deaths that happen in the homes [...].” (Stakeholder, SH02 (Government CHEW))

Stakeholders and HCPs reported that CHWs were effective in the services they offered particularly if appropriate training and facilitation were provided. As an example, one HCP reported having successively utilised CHWs to achieve control of a communicable disease:

“Yeah, they do play a role, especially when it comes to the management of communicable diseases where I said am the lead role in the management. I have engaged them so much, because they are the ones who helped us especially in eradicating cholera in Naivasha Sub-county Hospital, and we have a zero mortality rate. So in communicable diseases they are very good, and the district medical officer for health has taken the initiative to train them when it comes to such. So if it also takes an initiative on training them on how to handle, sexual assault, and sexual defilement and sexual violence cases, it will also be very good.”
(Professional healthcare provider, HCP3)

While the evidence show that HCPs recognised CHWs, in contrast, most CHWs felt that HCPs did not recognise them as partners in healthcare. This possibly illustrates different expectations from the CHWs on how the HCPs could show appreciation of the CHWs roles. Dialogue between the CHWs and HCPs on their different expectations could resolve this issue.

7.3.4.2 Roles of CHWs in sexual violence services identified by stakeholders and HCPs

The potential of CHWs providing services for sexual violence survivors was expressed by all stakeholders and HCPs. Stakeholders and HCPs identified various roles that CHWs already play in sexual violence services and others that they could be trained to play. These include provision of information, identifying survivors at the community level, accompanying survivors to hospital, providing treatment follow-up and psychosocial support.

CHWs as sources of information: Currently, CHWs play a role in giving sexual violence information to the community. The role of giving information was particularly appropriate as CHWs were closer to the community. Moreover, HCPs recognised a distinct advantage that CHWs had over professional healthcare providers in dealing directly with the community. Being members of their own community, they understood the community better, knew the problems in the community, spoke their language and could better communicate with their people. CHWs have opportunities to pass information on a one to one basis while visiting households and during normal day-to-day interactions with community members. Additionally, they can also educate groups of people within the community such as school-going children and other community gatherings.

“Ok, provision of information, I know that one they are really trying because as I’ve told you now the kind of victims that we have. We usually sit down with them and we tell them the kind of people that we always see and the victims here. So when we let them know about the victims that we have, now it’s their initiative, they usually go to schools for health education. So they are trying to sensitise and the good thing with them is that you know for some of us due to staying in the hospital now we are just used to these medical terms. But at least for them when they go out they know how to let the people know. So understanding in the community will be much better when they talk to them. So when we just go for the meetings for us it’s just like reminding them.” (Professional healthcare provider, HCP5)

CHWs role in identifying survivors and accompanying them to the hospital: Because CHWs were in direct contact with the community, they often identified survivors and brought them to hospitals. This is a crucial role given the fact that many survivors do not seek formal healthcare. Thus, CHWs being able to identify them at the community level may lead to more survivors accessing healthcare.

“I interact with them (CHWs) here because some of them identify those cases of sexual violence in the community and they are the ones to accompany them to the facility. They just bring them here and when they are here I do the necessary.” (Professional healthcare provider, HCP4)

CHWs role in follow up: Follow-up was another area where all the HCPs felt CHWs can play a significant role in sexual violence services. As CHWs were based in the community, they had more contact with survivors once they left the hospital. As many survivors did not come back for return visits to the hospitals, CHWs could support the survivors to complete treatment, provide some psychosocial support and provide a link between these survivors and the health facilities.

“That’s why am saying if facilitated, I think they can do a better job. Because they can track down these cases, ensure there is intake of the PEP and give feedback.” (Professional healthcare provider, HCP2)

“It will be very good if we engage them. Because community health workers, they are in contact with these patients most of the time.” (Professional healthcare provider, HCP3)

There was evidence that CHWs were capable of providing follow up. One interviewed stakeholder from a local NGO reported that her organisation had used CHWs to follow up survivors including tracing those lost to care and interviewing them. They found that CHWs were effective in this role and were acceptable among survivors. During informal discussions, several other stakeholders reported utilising CHWs in similar activities.

“One time we were following up survivors and we actually, what we did we called the survivor, we asked them if they would like to be followed. Many of them did not have a problem. And some of them said whatever you want to ask me just ask me on the phone. So, they [CHWs] followed the survivors and they asked them questions. So I feel if the community is aware that community health workers can be able to follow them, then it can be a good thing. And even them if they have the information you know they would talk about it in their own language, because most of them are in their local areas. And then when they are doing their household, they will sensitise. So those households will be reached with the information.” (Stakeholder, SH03 (Gender technical officer in a local NGO))

Treatment and psychosocial support: A few stakeholders and HCPs felt that CHWs could be trained to provide treatment particularly emergency contraceptive to survivors. This was commensurate with the fact that CHWs have been used to provide family planning in some settings in Kenya and also the emergency contraceptive pill is a non-prescription drug in Kenya. Additionally, as CHWs were in close contact with survivors, they could be trained to provide psychosocial support including basic counselling.

“If they were trained maybe they could even set up a support group within their community, if they know there are people who have undergone that. They can be able to give emergency contraceptive because that one you can just buy over the counter, and they can be able to refer as soon as possible for PEP.” (Stakeholder, SH03 (Gender technical officer in a local NGO))

7.3.4.3 Barriers to CHWs services as reported by HCPs and stakeholders

All the HCPs and stakeholders observed that the roles that CHWs played should be dependent on the type of CHWs, the training received and areas served. There is thus a big need to map out the CHWs currently in healthcare and other potential community resource persons who are currently not recognised as CHWs.

“I think that it’s a good idea [using CHWs in sexual violence services]. I think it would be kind of important to map out who are the other community resources

beyond the typical CHWs that we've not really thought about or have overlooked but they could be a bit better educated and you know could really serve as an even bigger resource [...]. I think for an issue such as sexual and gender based violence there would be a need to sort of really dig a bit deeper and say are these the ones we must use? Maybe they are. There might be other people that we haven't thought about, maybe because of the sensitivities that we have around violence [...] who would technically qualify as community health workers but maybe we don't see them as such. You know, but they are community resources in their own right, but maybe we just haven't seen them as such [...]. We have talked about community midwives. You know, it could be these young nursing students; some of them haven't gotten a job yet, instead of hanging around in the villages [...]. There were the medicine shops, the little pharmacies. There might be a range of people, I think mapping, just to know, you know, who is this here- and then deciding maybe these people could also fall under the umbrella of community health workers.” (Stakeholder, SH01 (International NGO researcher))

As this stakeholder points out, there is need to consider which CHWs to involve in sexual violence and this may depend on their level of education and qualifications. Basic entry level CHWs including those already working within communities with no training and potentially other community resource persons such as local shopkeepers can create awareness in the community, can be good sources of information to survivors and can provide referral to the next level of care. With selected cadre of CHWs (such as midwives, retired nurses and other health workers) and training, CHWs can provide basic counselling, set up support groups, provide emergency contraceptive and follow-up.

“If they are given the necessary training maybe they can be able to give the psycho-social support. Or maybe we can also use, I don't know maybe we have got retired nurses there, we have retired health workers there. So they can also be brought on board, because they are of great help. Because they live within the community, they are retired, they are living within the community, you see these retired people also are, can be very, very resourceful.” (Stakeholder, SH02 (Government CHEW))

The emphasis on training was clear. It was widely observed that CHWs were ill equipped for handling sexual violence survivors. Professional healthcare providers pointed out that CHWs lacked specific knowledge and skills that are crucial to dealing with sexual violence

survivors. Counselling for instance was mentioned as one area that CHWs would need to address in survivors but which they were not trained in.

“No, no, no they are not equipped. Most of them are not trained in counselling and they don’t know the medico-legal rights. They also don’t know if there is any safe place or safe house for such [for survivors].” (Professional healthcare provider, HCP3)

“I was also feeling that they should have the basics of counselling because once these survivors go back to them they should know how to handle them especially on psychosocial support. So I would wish they undertake such training so that they are capable of doing that.” (Professional healthcare provider, HCP4)

These concerns on training in counselling correspond to those raised by CHWs themselves. As some observed, they lacked the skills needed in counselling and often ended up telling survivors what to do rather than helping survivors make informed decisions.

Similarly, some of the HCPs and stakeholders had concerns about the ability of CHWs to be confidential. One observed that although they could be trusted with many responsibilities in the community, they might not be able to deal with sensitive matters that required a high level of confidentiality such as sexual violence:

“Okay, it’s something I have been thinking about doing [using CHWs to follow up violence survivors]. But the challenge is, like I have told you being an urban setting, some of the community health workers, we don’t know how they will take this information. Whether they will keep it a secret or they will just go telling everybody so and so was beaten up by the husband or something. Sometimes I find it challenging, sometimes I find that I would rather do it myself personally than asking a CHW to help me.” (Stakeholder, SH02 (Government CHEW))

In contrast, the majority of the CHWs pointed out that they understood the importance of confidentiality in their line of work. Those interviewed reported that they knew not to divulge any client information to others and that the reason community members came to talk to them was because they knew the CHW would not go around talking about their

issues. The lack of confidentiality may also reflect the lack of training reported and can be addressed through better training.

7.4 Discussion

Generally, all four groups of participants interviewed (survivors, CHWs, HCPs and stakeholders) perceived CHWs services for sexual violence to be acceptable and feasible. Similar to findings from the systematic review (chapter 4), CHWs' involvement in sexual violence services was found to be beneficial. Several areas where CHWs were already playing a significant role, and also where they could potentially be even more useful to sexual violence survivors were identified: as a source of sexual violence information including what to do and where to go when it occurs; identifying survivors within communities; educating communities on sexual violence; for treatment follow up; for referral and linkages to healthcare and other services; accompanying survivors to various services; providing psychosocial support; and, organising and facilitating support groups. Notably, these roles are largely identical to those identified by the systematic review.

These findings suggest that CHWs are a potential flexible and accessible alternative route for certain healthcare services for survivors. However, for CHWs to effectively offer services to survivors, efforts to equip them with the right skills and tools should be made. All participants highlighted the need for training with CHWs reported as lacking in specific skills and knowledge to deal with survivors. For instance, while psychosocial support was reported as one of the main areas where CHWs provide support to survivors, nearly all CHWs had no training in basic counselling. The WHO recommendations for training sexual violence service providers such as doctors and nurses include offering basic knowledge about violence such as relevant laws, knowledge of existing services that might offer support to survivors and appropriate attitudes towards survivors. It further recommends that the content of the training should be appropriate to the context and setting, and should also pay attention to the effect that caring for survivors has on healthcare providers such as vicarious traumatisation [119] . These areas of training are similarly important to CHWs and are currently lacking.

Chapter 7: The role of CHWs in sexual violence services

Participants in this study highlighted the importance of CHWs upholding the confidentiality of survivors and training on this should also be emphasised. Confidentiality is particularly relevant as CHWs reside in the same community as survivors. Additionally, CHWs' attitudes may be shaped by community norms and have the potential to further stigmatise and isolate survivors. Patients with stigmatising conditions such as HIV are known to exhibit preference for more distant services or CHWs from a different community often preferring to travel long distances to seek care rather than attend treatment in the nearest health facility to their home [140]. Survivors who had not received services from a CHW expressed similar fears that CHWs from their area of residence may reveal their abuse to other community members. In contrast, survivors who had received services from a CHW found her trustworthy and reported no breach in confidentiality. Thus, the selection of CHWs and building of confidence among survivors is important.

The issue of safety when dealing with sexual violence was a major cause for concern among CHWs. Although healthcare providers in Kenya are not expressly required by law to report sexual violence, the legal and justice systems are intrinsically connected to healthcare [80]. Healthcare providers in hospitals are required to conduct a full medical forensic examination, document and collect forensic specimens and can be called upon to provide evidence in court as an expert witness [80]. As such, seeking healthcare is often seen as the first step to seeking justice and CHWs assisting survivors access healthcare can therefore be viewed as a threat. Similar to other studies in the region, relatives of perpetrators protected the perpetrators to avoid bringing shame to the family or losing a breadwinner [189, 190]. There is therefore need to educate both the community and CHWs on the distinct roles of CHWs assisting survivors access healthcare which are independent from reporting the violence to the police and justice system.

Having local knowledge of the community was identified as one of the strengths of CHWs and that meant that CHWs often had information on survivors within the community who had not sought healthcare. Interviews with survivors revealed that on many instances, other people were influential in their seeking healthcare either by giving them advice to do so or actively taking them to the hospital (chapter 6). Thus, one potentially important

role that CHWs could play in sexual violence care is getting survivors who would otherwise not seek healthcare to act. Having the right approach to these survivors could enable them access the necessary care.

Limitations

As noted in the findings, the majority of the experiences of survivors with CHWs were primarily with one particular CHW. While the experiences of these survivors with this CHW cannot be generalised, they point to a very successful model of CHWs' services that can possibly be replicated. In addition, willingness of other survivors who had not used a CHW to use them further supports the acceptability and feasibility of such services.

Conclusions

It was evident from this study that despite the lack of formal recognition as sexual violence service providers or relevant training, CHWs already play some roles in survivor pathways and are viable partners in the care of survivors. The roles of CHWs as being an accessible source of information together with psychosocial support were cited as potentially where CHWs have the greatest impact. Additional roles such as identifying survivors, accompanying them to various services and appointment reminders can further support survivors and make the process of healthcare seeking less solitary.

Although CHWs already report a high workload, formally involving them in sexual violence services does not create any new responsibilities for them but reinforces what some are already doing. Moreover, formal recognition that CHWs do and will continue to interact with survivors may lead to more efforts to strengthen their skills for them to perform these roles better. Nevertheless, there is limited data available on CHWs services for sexual violence (chapter 4). More studies are needed to explore different models of services, training required, feasibility of providing these services and the specific roles and responsibilities for CHWs.

Chapter 8: Synthesis of findings, discussion and recommendations

The aim of this study was to explore sexual violence survivors' experiences of seeking healthcare and to understand the benefits and drawbacks of using CHWs to provide support health services to sexual violence survivors. This research was informed by three critical observations: 1) Despite significant health complications, survivors of sexual violence often fail to access or complete recommended treatment; 2) Limited mechanisms exist to support survivors to access and complete care particularly at the community level; and, 3) While CHWs certainly interact with sexual violence survivors at the community level due to their nature of work, and various stakeholders are adapting them for sexual violence services, there is limited data on the models, benefits or drawbacks of CHWs services to sexual violence survivors. In this final chapter, findings addressing these concerns are summarised and discussed in the context of existing research on sexual violence services and CHWs. Limitations of the study are then described, conclusions drawn and recommendations from the study findings outlined.

8.1 Summary of findings and discussion

My research used a mixed methods approach. I conducted a systematic review of both qualitative and quantitative studies on CHWs services for sexual violence published in seven databases. I also conducted in-depth interviews with 49 participants (survivors, CHWs, healthcare providers & stakeholders) and analysed data on 543 survivors treated at two regional hospitals and 1,680 national survey respondents. The findings from these different sources can be summarised into four key findings:

1. Survivors follow different pathways when accessing and using healthcare, and, these pathways are dependent on circumstances around the violence, support received from other people and availability of services.
2. Specific barriers and individual survivor characteristics contribute to multiple missed treatment opportunities for survivors occurring at both the community level and health facility level.

3. Although not in a coherent way, community health workers are already involved in the healthcare pathways of sexual violence survivors and their services are acceptable to survivors and other stakeholders.
4. Community health workers' support services can address some of the barriers identified along survivor pathways but available research evidence on models, acceptability and feasibility is limited and of poor quality.

8.1.1 Pathways of care for survivors accessing and using healthcare

Different survivor experiences showed multiple pathways accessing healthcare, during the care and after (figure 8.1). Survivor pathways were highly dependent on individual circumstances and other barriers to healthcare at various stages. There were different pathways of informal disclosure- immediate, delayed, non-disclosure or involuntary disclosure. Voluntary disclosure was dependent on availability of a trustworthy person and stigma was a strong barrier to disclosure. Non-disclosure generally resulted in survivors feeling isolated and with a higher likelihood of not seeking healthcare. People disclosed to varied and were noted to play an important role in the survivor seeking healthcare- either facilitating healthcare seeking or contributing to delays.

Various reasons for seeking healthcare were reported, most importantly HIV, STI and pregnancy prevention. Some survivors presented for treatment within recommended periods, others presented only after complications developed and others did not. Even after presenting for treatment of symptoms related to violence, some survivors chose not to disclose violence to healthcare providers. Within the hospital, there were different pathways, with survivors having to attend multiple service delivery points. Waiting at different service delivery points and interactions with healthcare providers affected the level of satisfaction with services and completion of treatment. Community support after the violence was limited and consisted of CHWs and peer support groups.

This study highlights the crucial role of disclosure, both informally and formally, and its implications for healthcare. Survivors are more likely to miss treatment if they do not disclose informally and more likely to get the wrong treatment and develop complications

if they do not disclose violence to healthcare providers. When the right person is disclosed to, positive gains in different areas of life occur over time- psychological, physical, financial and social well-being. This is consistent with other research on effects of disclosure to survivors [169, 191, 192]. Nonetheless, disclosure is not easy and carries a high social cost for the survivor if the wrong person is chosen for disclosure- survivor might not be believed, might be blamed for the violence, might loss social status in the community and face isolation. Research indicates that these negative social reactions can lead to survivors stopping further disclosure, negatively impact recovery and lead to development of complications such as post-traumatic stress disorder and depression [170, 192-194]. Therefore, it is important to identify available, acceptable and appropriate initial providers at the community level to support survivors. Some researchers have indicated that disclosure and acknowledgement of assault without further support can be more detrimental to survivors than some negative reactions [195], hence these providers could be trained to respond to survivors in ways that promote well-being including support to seek healthcare. In this study, CHWs were identified as possible close to community providers who could provide this type of support to survivors.

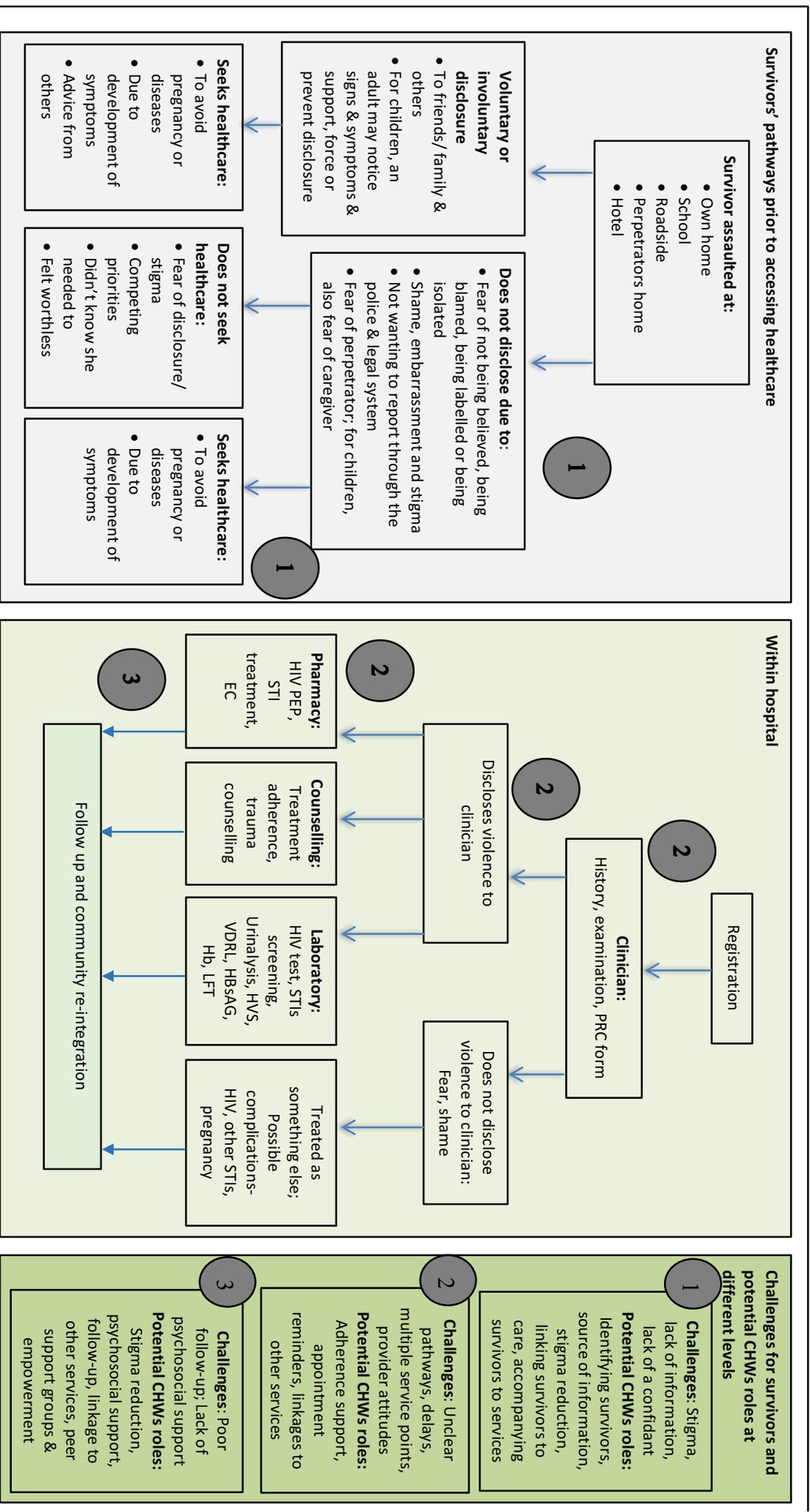


Figure 8.1: Survivor pathways of healthcare, challenges and potential CHWs roles

2

Numbered circles represent levels where survivors encounter challenges and where CHWs can potentially be used to address the challenges.

CHWs: Community Health Workers; EC: Emergency contraceptive; Hb: Haemoglobin; HBSAg: Hepatitis B surface antigen; HIV: Human Immuno-deficiency Virus; HVS: High swab; LFT: Liver function test; OPD: Outpatient department; PDT: Pregnancy detection test; PEP: Post exposure prophylaxis; PRC: Post rape care; STI: Sexually transmitted infection Venereal disease research laboratory

8.1.2 Specific barriers and individual characteristics contribute to multiple missed treatment opportunities for survivors

Comparison between characteristics of survivors treated at the hospitals and national survey respondents identified specific groups of survivors missing out treatment nationally. Older survivors, partnered or ever partnered survivors, survivors experiencing intimate partner violence, children experiencing violence in schools and males are unequally represented among survivors getting treatment. Although, children constitute the largest proportion of survivors being treated in the hospitals, national data indicates that the majority of sexually abused children do not seek healthcare. Additionally, many of those who seek healthcare present late at the hospitals and therefore do not get recommended treatment.

In-depth interviews identified challenges within the hospitals and in the community that hinder quality care. The different categories of respondents were generally in agreement on the different barriers. The main challenges identified along the care pathways were:

- 1) Knowledge gaps: It was evident that survivors lack crucial information on what to do after violence, where to go and when. Survivors need to get prompt healthcare to deal with the immediate consequences of violence and array long-term complications. Many survivors also reported not having someone they could talk to. Even among those who talked to different members of the community and formal service providers, lack of appropriate information and misinformation was found.
- 2) Lack of acceptable and appropriate care providers at the community: There were limited community support mechanisms for survivors. There was no clear appropriate and trustworthy person at the community level to support survivors. Survivors found it difficult fitting in the community and many expressed the need for continued psychosocial support.
- 3) Healthcare system gaps: Poorly structured services with unclear pathways, multiple service delivery points and HCP-related issues such lack of training and negative attitudes were identified. These caused delays in services

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provision, frustration among survivors, re-victimisation and survivors lost in the healthcare system.

- 4) Lack of follow up: There were no formal follow-up mechanisms for survivors once they were discharged on treatment and this resulted in some not completing treatment. Survivors experienced challenges taking treatment but had no one at the community level to support them.
- 5) Economic vulnerability: Financial vulnerability was a trigger for violence in most of the women interviewed (attacked on their way to work very early in the morning or late in the evening from work, at place of work or by potential employer); hindered women from seeking treatment (had to report to work first, couldn't get time off work for return visits or had trouble scheduling treatment taking); and, financial vulnerability followed violence (loss of job due to physical and psychological effects of violence as well as further financial burden due children born of rape). Thus financial need and sexual violence appear to be in a vicious cycle with one exacerbating the other.
- 6) Stigma: Sexual violence stigma was prevalent in the community, and to some extent at the hospital, and was closely linked to HIV stigma. Stigma manifested in fear of being isolated, not getting a spouse, being abandoned by spouse, being labelled a bad person or HIV-infected; stigma prevented disclosure and therefore healthcare seeking; and, stigma affected scheduling of medication taking for survivors due to the need to hide.

An important health implication from this study is the urgent need to implement interventions to reach group of survivors missing out on treatment and/or getting lost to follow up. One overarching factor among these groups is social stigma experienced at the community and hospital level leading to misinformation, failure to disclose, failure to seek or complete treatment and social isolation. Social stigma has been identified as a barrier to seeking treatment and completing HIV PEP in other African settings [41, 189]. For instance, in a qualitative study interviewing women attending services in South Africa, many of whom did not complete treatment, stigma and perceptions of being blamed for the violence were cited as

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strong barriers to treatment completion [41]. Thus, any interventions to reach these groups should address social and cultural norms that propagate sexual violence and stigma or risk excluding the survivors further.

Overall, financial vulnerability appeared to play a strong role in sexual violence: as a cause and consequence of violence as well as a barrier to healthcare (figure 8.2). This is in line with other studies in GBV that have reported a strong correlation between poverty and violence [196], and, that structural interventions such as micro-finance may be effective in reducing GBV in African settings [197, 198]. However, these studies have focussed on IPV particularly physical IPV. The relationship between poverty and non-partner sexual violence is less studied but has been recognised among women of colour in the United States of America [199]. While the above study refers to women from a developed country, which is vastly different from Kenya, this study's findings suggest that this too may apply locally. To comprehensively address sexual violence, this needs to be further explored in the local setting with an aim to not only develop interventions that will prevent the violence but those that will address poverty as a barrier to healthcare access and recovery.

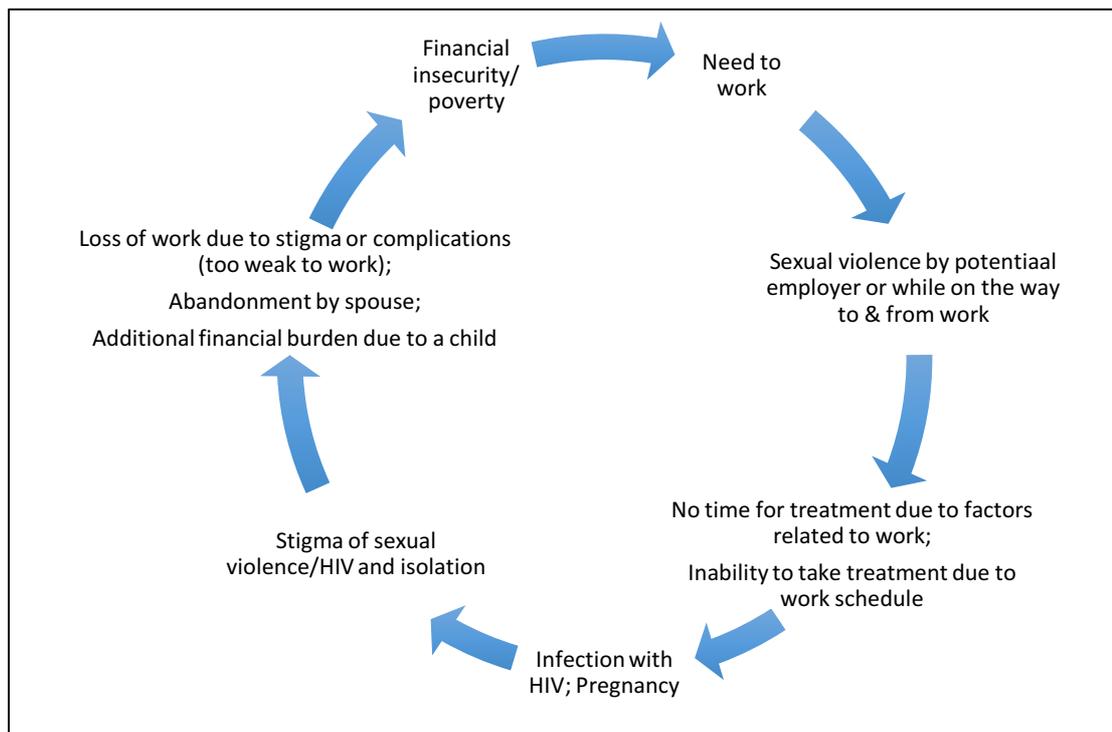


Figure 8.2: Cycle of poverty and sexual violence

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The need for training of HCPs was evident. Research evidence has shown that training on management of sexual violence improves HCPs knowledge and clinical management of survivors [119, 196]. This study found that very few HCPs had received training on management of sexual violence and protocols for managing children and adolescents were lacking. Previous research has similarly highlighted the need for training among service providers treating sexual violence survivors in Kenya [6]. A recent study highlighted the poor quality of services provided to children survivors in Kenya reporting that providers were not skilled in obtaining consent, conducting physical examination and collecting specimens [163]. In addition, while acute care is provided at the hospital, no guidelines exist on the long-term care of abused children. There are no formal referral and linkage mechanisms to child protection systems including children's officers, safe shelters and community organisations. The findings of this study together with the other studies mentioned support training of HCPs and the urgent need to develop guidelines and protocols for treating and referring children and adolescents.

Not only are protocols for treating children and adolescents lacking, but also policy on their treatment is problematic. The National Adolescent Sexual and Reproductive Health Policy clearly emphasises the importance of sexual and reproductive health services for adolescents and gives guidelines on the services to be provided [200]. The policy advocates for promoting sexual and reproductive health and rights of adolescents; reducing early and unintended pregnancy; reducing SGBV and improving response to SGBV among others. The government also has a policy for providing youth friendly services, which requires additional training of staff, structural and operational adjustments to specifically attend to the needs of adolescents and young adults [201]. While these policies suggest that sexual and reproductive health services should be freely available to adolescents, there is no clarity on what age children can seek these services independent of their parents consent. Other policy documents indicate that parental consent is required for children to access certain services. The Children's Act for instance states that provision of medical care for children is the responsibility of the parents and the government. Additionally, certain services constituting part of post-sexual assault

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care such as HIV testing can only be provided to children below 18 years with the written consent from a parent or legal guardian (except for emancipated minors) [202]. This may pose a problem for healthcare providers attending to unaccompanied minors. Older adolescents experiencing sexual violence but not necessarily wanting to disclose to their parents may find accessing services difficult. There is clearly a need to define ways that adolescents can independently access sexual and reproductive health services including post-assault services. Policy in this area should also address the role of parents in the treatment of older adolescents in consensual sexual relationships. Previous studies in Kenya show that sexual activity is common among adolescents with 40-60% of 15-19 year old being sexually active [1, 203]. In the current study, instances of adolescents in such relationships being presented for treatment by parents as cases of sexual violence were reported.

8.1.3 Community health workers are already involved in the healthcare pathways of sexual violence survivors

The systematic review showed that although limited in both quantity and quality, available studies indicated that there was involvement of CHWs in sexual violence care and that this involvement was potentially beneficial. Furthermore, survivors interviewed indicated a willingness to receive services from CHWs and those who had used their services reported positive interactions. Healthcare providers, CHWs and stakeholders also confirmed involvement of CHWs in sexual violence services and pointed out various roles that CHWs could potentially play to improve services for survivors. The roles as identified by different groups of interviewees were largely similar and also aligned with those identified in the systematic review (table 8.1).

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Table 8.1: Roles of community health workers as identified by different groups of interviewees

Role	Sexual violence survivors	CHWs	HCPs	Other stakeholders (NGOs, MOH)	Systematic review
Awareness creation in the community	✓	✓	✓	✓	✓
Identifying survivors at the community level	✓	✓	✓	✓	✓
Providing information directly to survivors	✓	✓	✓	*✓	✓
Accompanying survivors to services	✓	✓	✓		✓
Linkage to services (e.g. referral to healthcare, police, social services)	✓	✓	✓	✓	✓
Follow up (e.g. ensure adherence, provide information on side effects etc.)	✓	✓	✓	✓	
Basic counselling	✓	*✓	*✓	* ⁺ ✓	✓
Some treatment (e.g. emergency contraception)				* ⁺ ✓	✓
Facilitating support groups	✓	✓	✓	✓	✓
Rehabilitation/re-integration into the community (e.g. teaching income generating activities)	✓				
Others (e.g. food (to be provided by government), finances, friendship, school)	✓	✓			

**To provide service with training; ⁺only certain cadres to provide service; Abbreviations: CHWs: Community health workers; HCPs: Professional healthcare providers; NGOs: Non-governmental organisations; MOH: Ministry of health*

The roles identified are crucial in improving healthcare for survivors. For instance, awareness creation has the potential to change disclosure patterns, quality of support received from informal sources, healthcare utilisation and community stigma levels. A study in neighbouring Tanzania for instance found that an intervention to increase awareness in the community resulted in increased knowledge among community members; changes in social norms that perpetuate violence; and, more than 50% increase in survivors seeking treatment in health facilities [204].

It was generally agreed that CHWs were not qualified to provide treatment for sexual violence survivors. However, provision of emergency contraceptive was viewed as a possible exception as these do not require a doctor's prescription and are sold over the counter in Kenya. Research further supports this role as CHWs have been found to be effective in providing contraceptives including long acting methods in different settings [141] [63]. The systematic review also identified provision of STI treatment and wound care as roles played by CHWs in one study. Delivery of refill doses of HIV PEP in line with practices in HIV care in some areas is

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also potentially possible [126]. However, all these roles have not been evaluated locally and require further research.

Other less established but frequently reported roles by survivors included CHWs support in other personal issues unrelated to sexual violence such as education, food and financial support. Some of these roles have been documented in other conditions such as delivery of food baskets to TB patients as a component of a CHWs' intervention [51]. However, given the fact that most of the CHWs reported personal financial difficulties, caution is advised on these roles. Furthermore, CHWs also reported being viewed with suspicion by some community members about their genuineness to help rather than doing the work for personal gain. Thus, such roles may compromise service delivery. Educating the community on what CHWs can provide as well as identifying other ways of supporting needy survivors will go a long way in addressing survivor expectations.

The study findings suggest that CHWs services can address some of the existing challenges that survivors face in accessing and utilising healthcare (figure 8.1). Although there was consensus that CHWs were already involved in sexual violence services, these services are not formally recognised in Kenya. This lack of recognition is perhaps best reflected in the lack of training in sexual violence observed among CHWs. The few CHWs who had some basic training in sexual violence services received the training from different NGOs. This implies that the training is likely not standardised and has not been evaluated. Thus identifying the training needs and developing protocols for training is paramount. Ultimately, this role will also require close supervision that is currently lacking. This supervision should not only address the usual work performance but should also include addressing safety concerns when they arise, advising CHWs on levels of involvement with survivors and providing appropriate referral mechanisms. Additionally, there were different ideas from different interviewees on what roles CHWs can play and the cadre of CHWs who should carry out certain roles. Thus, there is need for mapping of CHWs and identifying specific roles for each cadre.

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For CHWs to deliver these services effectively, support to overcome the other challenges identified is required. Consistent with other studies, a high workload, poor definition of roles, lack of recognition, lack of support, poor supervision and lack of incentives were reported barriers to CHWs [44, 45, 142, 143]. High workload is clearly an issue and may raise the question of whether involving CHWs in sexual violence services should be recommended. This study finding is that CHWs are already involved; they report a high level of sexual violence in their communities; and, were all enthusiastic about helping survivors. Therefore, formally equipping them for this task does not necessarily add a new role but enhances what they are already doing. Nevertheless, more investigation is required in this area as there may be aspects of formalising their role that does lead to increased duties, which are hard to predict at this stage. Additionally, formalising the CHWs role could increase awareness and demand and therefore workload. This further supports the need for mapping and identifying which kind of CHWs can effectively deliver specific types of services to survivors.

Currently, CHWs lack the supportive structure necessary for them to provide effective services to sexual violence survivors. In particular, there is an apparent disconnect between CHWs and healthcare professionals providing care to survivors of sexual violence (figure 8.3). The CHWs' services fall under the preventive and promotive health services arm of the Ministry of Health in which CHWs are under the supervision of CHEWs [84]. In contrast, post-assault care for survivors of sexual violence is provided under the curative and rehabilitative health services arm of the ministry. Thus, there is no formal link between CHWs and the professional healthcare workers providing treatment and follow up services to survivors.

Evidence from this study suggests that current supervision of CHWs is irregular and does not substantively address specific issues facing CHWs. For CHWs to effectively provide services to sexual violence survivors, comprehensive support and referral networks need to be established. The lack of a direct link with the health facilities and healthcare providers attending to survivors should be addressed to ensure smooth referral of survivors to the facility and continued follow up at the

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community. One way that this link can be established is by having a contact healthcare provider at the health facility who is formally recognised as a CHWs' supervisor and sexual violence services case worker. This person should be mandated with the roles of ensuring coordination, appropriate training, supervision and addressing the issue of vicarious trauma in CHWs providing services to survivors.

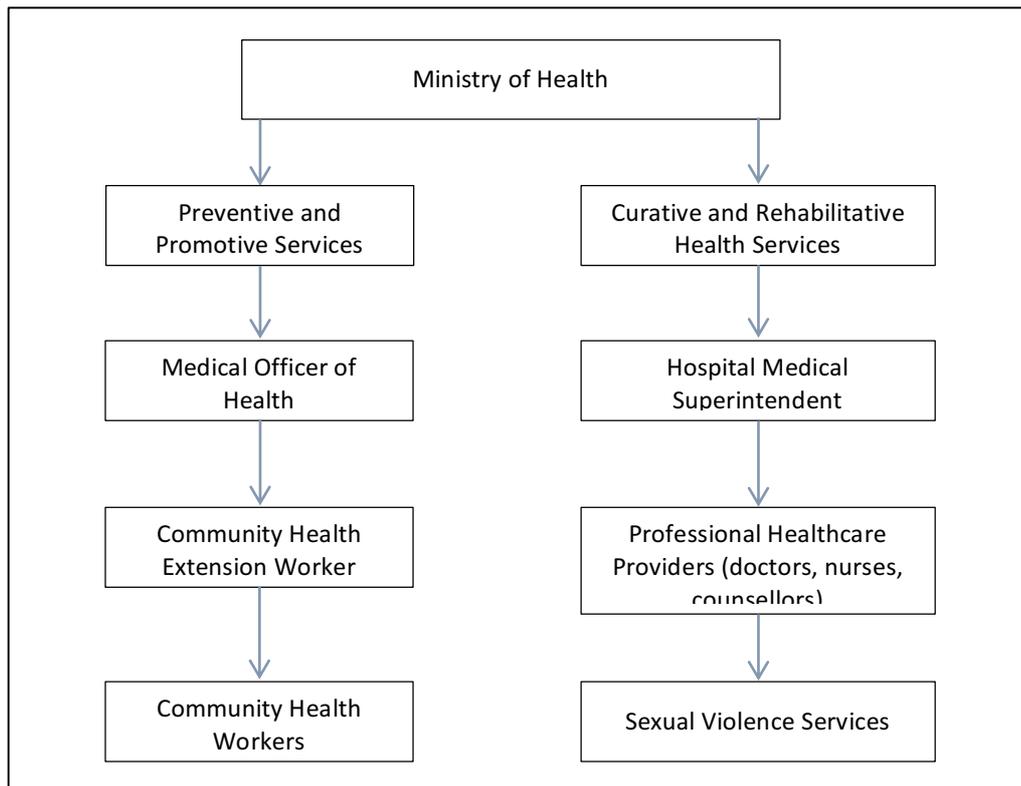


Figure 8.3: Diagram illustrating the different Ministry of Health's paths for supervision of community health workers and provision of treatment for sexual violence survivors.

Another area that needs attention for CHWs to be effective is the apparent link between health services for survivors and reporting of violence to the police. Although not expressly required to report sexual violence to the police, healthcare providers are closely linked to the legal and justice process for survivors. The national guidelines for the management of sexual violence state that it is the role of the healthcare provider attending to a survivor “to inform and forward to the investigating police officer” the forensic samples collected from the survivor [80]. Additionally, though not mandatory for treatment to be provided, some of the

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survivors also reported being asked to go for the P3 form (police record form) from the police station by healthcare providers. This apparent linkage of health services for survivors and the legal and justice system was of particular concern to CHWs. Many CHWs had reservations about being seen to assist survivors to access healthcare as this was often linked to reporting the violence to the police and CHWs feared retaliation from perpetrators. There is need to explore ways to make clear distinctions between accessing treatment and reporting to the legal-justice system as this may encourage CHWs to assist survivors more.

Moreover, the link to the justice system may be a barrier to some of the survivors seeking healthcare. Evidence shows that some survivors, especially survivors assaulted by known perpetrators, are reluctant to report the violence due to factors such as fear of retaliation and embarrassment [205, 206]. Ensuring survivors can access all post-assault treatment- including having forensic samples taken- and only report to the police if they wish to, can encourage survivors who might otherwise not want to report to the police, to seek treatment.

8.1.4 Community health workers' services can address some of the existing gaps in healthcare for survivors but research evidence is limited and of poor quality

Although this study shows evidence that CHWs services for sexual violence are potentially beneficial, these findings are not conclusive. Many questions regarding these services remain unanswered. These questions largely relate to potential models of CHWs services- what works, for who, when and where- in other words, what services can be provided effectively by CHWs and to which survivors. For instance, there were notable differences between survivors who had recently experienced violence and those who had experienced violence much earlier with more recent survivors not having received services from CHWs and preferring CHWs from outside their community. Similarly, CHWs reported more experiences assisting children compared to adults. Thus, given the stigma of sexual violence, should CHWs work within their own communities and should they target certain age groups or all survivors. Moreover, interviews with CHWs, HCPs and

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stakeholders indicated that CHWs are inadequately equipped to provide services and their roles are poorly defined. Therefore the question of what is appropriate training for CHWs arises- what content should it cover, how long should it be, who should provide it and how frequent should refresher courses be. All these issues and others such as the exact roles of CHWs, their supervision and motivation need to be addressed if CHWs are to be effectively utilised to assist survivors.

This study found one model of CHWs services which seems to be working in Kenya and was positively appraised by the survivors who had used it: an NGO-trained and supported CHW; specialised SGBV advocate; and, working at the community level mainly creating awareness, identifying survivors, providing linkages and psychosocial support. As these survivors were few and selective, it is difficult to make conclusions based on these findings alone. Similarly, the systematic review identified a few models that have been used but none of these models have been tested and/or evaluated in the Kenyan setting or elsewhere. Further assessment of other models that may be undocumented in Kenya as well as formal testing of models used elsewhere is necessary.

8.2 Limitations of the study

With regards to quantitative data, the health facility data are routinely collected for healthcare purposes but not tailored to research; therefore the data were incomplete. Efforts were made to find missing information and ensure data used were good quality. Data were collected from only two health facilities. While these two hospitals are not representative nationally, they are better than most previously done research as they are both referral hospitals in two different counties and are therefore likely to capture a more holistic picture of the survivors in Kenya. The KDHS data excludes children below 15 years and therefore, no comparisons for this age group could be made. Additionally, although the KDHS collects data on sexual violence perpetrated by both intimate partners and non-partners, it puts more emphasis on intimate partner violence; therefore the findings should be viewed in light of this.

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With regards to qualitative data, sexual violence is a sensitive topic which participants may find difficult to discuss and may limit the validity of data collected. To overcome this, individual in-depth interviews were conducted and privacy was ensured during the interview. Participants were also assured of their confidentiality. My previous experience interviewing and treating survivors allowed me to develop rapport easily with the participants.

Acceptability of CHWs was considered in general without paying attention to specific socio-demographic characteristics of CHWs that may influence their acceptability and performance. Data were not collected from survivors on preferences for personal CHWs' characteristics such as gender, age, education, marital status etc. These characteristics could be relevant in the willingness of survivors to receive services from CHWs. Preference by some survivors for CHWs from a different community were reported; differences among female and male CHWs in the way they handled survivors were observed; and, HCPs and stakeholders recommended a certain cadre for CHWs providing sexual violence services. These data were limited and need deeper probing.

Despite intentions to recruit emancipated minors, this unfortunately was not achieved due to difficulties in reaching this population. Given that the majority of survivors are children and adolescents, their views on the services received and CHWs' services are important. Community health workers also reported frequent contact with sexually abused children and their caregivers and more data in this area is required.

The participants for the qualitative data collection were chosen purposively and therefore their views are not representative of the general population. Limited numbers of interviewees in each group means that theoretical saturation may not have been reached. It was not possible to carry out more interviews given the limited time and resources available for the study. However, the aim of the qualitative study was to gain an in-depth understanding of the sexual violence

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survivors' and other stakeholders' views and efforts were made to maximise on the diversity of those chosen in order to get varied views.

Overall, triangulation of data from multiple sources has enriched the findings and recommendations drawn from this study.

8.3 Conclusions and recommendations

This study has identified specific barriers to services for sexual violence survivors and specific groups at risk of missing treatment. Community health workers can form a part of interventions aimed at reaching these specific groups and addressing barriers to treatment. The findings of this study are a valuable addition to a very limited body of knowledge on CHWs services for sexual violence.

The findings of this study carry important implications for CHWs involvement in sexual violence services and broadly for health services for survivors as follows:

Community health workers involvement in sexual violence services

- 1) CHWs are a valuable resource in sexual violence services and their formal involvement is recommended. Formally involving them in sexual violence services does not create any new responsibilities for them but reinforces what some are already doing. Moreover, formal recognition that CHWs do and will continue to interact with survivors should lead to more efforts to strengthen their skills for them to perform these roles better. Part of strengthening the role of CHWs to provide services for sexual violence should include establishing clear referral pathways between CHWs and the health system as well as other referral networks such as the child protection services. Effective supportive supervision structures such as identifying a specific sexual violence case officer at the hospital to coordinate linkages between CHWs and the health facility, ensure appropriate training of CHWs dealing with survivors, provide supportive counselling to CHWs to address vicarious trauma etc. should be established.

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- 2) There is an urgent need to address the high number of survivors not accessing healthcare or failing to complete treatment. Currently, healthcare seeking is self-driven and more proactive ways of identifying survivors and supporting them through treatment are recommended. Additionally, there is need to target specific survivor groups identified to be at risk of missing treatment. The government should implement interventions at the community level to support survivors in accessing healthcare. The findings of this study suggest that some of the interventions can be delivered by CHWs.
- 3) Among the strongest advantages of CHWs offering services to sexual violence survivors is the accessibility and continuity of the services they offer. Unlike healthcare professionals, CHWs reside within the community and are not subject to transfers from one facility to another. Thus, they can form longer-lasting caring relationships with survivors. However, high dropout rates among CHWs weaken service delivery and overburden remaining CHWs. Specific measures to address challenges contributing to high turnover of CHWs such as lack of/poor remuneration, high workload, poorly defined roles and terms of service etc. should be put in place. Other recommendations on the roles of the CHWs, target population and the support that CHWs need to perform these roles are summarised in table 8.2. More research is needed in this area and specific recommendations for areas of research are also outlined.
- 4) Addressing community stigma is vital for any interventions at the community level to be effective. More community awareness of sexual violence and educating communities on available services is needed. Mass awareness campaigns in the community and more targeted awareness creation among groups such as women groups, churches, schools, local administration and the police should aim to address cultural and social norms that perpetuate sexual violence and stigmatise survivors. These are activities that community health workers can carry out.
- 5) Establishing linkages between the education system and healthcare is extremely critical for obvious reasons: most survivors are children who are

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likely in school; many children nationally report violence in schools; and, in-depth interviews reported a few teachers identifying CSA at school. It is necessary to establish referral pathways between schools and health facilities. In addition to awareness creation in schools, as teachers are in contact with children who may be experiencing violence, it is important to train them to recognise and handle these children appropriately to ensure their well-being. CHWs are already playing a role in educating children and teachers in schools as well as providing linkage between schools and health facilities. This role should be strengthened.

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Table 8.2: Recommendations on selection, training and other support to CHWs; target population and roles of CHWs in sexual violence services; and, further research needed

Component	What to consider	Study findings	Recommendations and further research needed
Selection of CHWs	Age	The majority of the CHWs were over 40 years.	Although age did not appear to affect services delivered, there is not enough data to make recommendations on suitable age for CHWs, further research needed
	Gender	Most were women. Limited qualitative data suggesting men may be more reluctant to assist survivors, have less knowledge on sexual violence and hold stigmatising views	Not enough data to make recommendations, further research needed
	Education	The majority had primary or secondary education. In-depth interviews suggested a high cadre of CHWs to provide certain services for survivors	Level of education not important for services such as awareness creation but a higher level of education and training is required for more complex issues such as dealing directly with survivors. Mapping of current and potential CHWs not currently recognised as CHWs is necessary
	Residence	A few survivors would only be willing to receive services from a CHW who is not from their local community but those who have actually used CHWs favoured a local person	Residence may not be a significant factor if issues of confidentiality are well-addressed
Training of CHWs	Minimum training package	Most CHWs had no training in sexual violence services	Based on the roles CHWs are playing and recommended standards for other healthcare workers dealing with survivors, training should include basic information on types, risk factors and recognising SGBV; confidentiality and ethics; dealing with stigma; available services/referral options; and basic counseling
Support to be provided to CHWs	Remuneration and recognition	Currently lacking and de-motivating. The need to earn a living through other means increases workload and compromises services	Remuneration should be provided and other ways of motivating the CHWs identified. Research on what remuneration is appropriate locally and other forms of motivation needed.
	Supervision	Supervision currently lacking or of poor quality	Regular and consistent supportive supervision should be provided
	Tools	No tools specific to sexual violence currently available, no established referral pathways and available services directory to enable effective linkages	Referral forms and directory of services should be provided
Target population for CHWs	Survivors missing treatment	There are 'hidden' groups of survivors missing treatment due to high levels of stigma and these should be targeted	Need research on interventions to reach partnered survivors, those experiencing sexual IPV and men
	Age	Children in schools likely missing treatment and some CHWs already being called to schools to assist survivors or give talks	CHWs should conduct outreach in schools and provide linkage to healthcare
Services to be provided by CHWs	Various services	CHWs already engaged in various roles in sexual violence services	<p>Recommended roles:</p> <ul style="list-style-type: none"> • Awareness creation in the community and schools • Identifying survivors at the community level • Providing information directly to survivors • Accompanying survivors to services • Linkage to other services (e.g. referral to healthcare, police, social services) • Follow up (e.g. ensure adherence, provide information on side effects etc.) • Basic psychosocial support <p>Further research required on:</p> <ul style="list-style-type: none"> • Suitability of CHWs to provide treatment such as EC, HIV PEP refill, STIs treatment and wound care • Suitability of CHWs to provide group counselling and facilitating support groups • Suitability of CHWs to facilitate rehabilitation/re-integration into the community as suggested by survivors (e.g. teaching income generating activities) and others (e.g. food distribution)

Abbreviations: CHWs- Community Health Workers; EC- Emergency Contraceptive; HIV- Human Immunodeficiency Virus; PEP- Post Exposure Prophylaxis; STIs- Sexually Transmitted Infections

Additional recommendations for sexual violence services:

- 1) Establishing clear pathways within healthcare, explicitly defining the care package and providing a conducive environment for providing this care is imperative. There is need to streamline services at the hospital level by devising better ways of identifying survivors, reduce waiting time and other forms of secondary victimisation. The current receiving of services in a HIV CCC was reported as potentially stigmatising. Given the high levels of HIV stigma in the country and the potential effect on healthcare utilisation, it is questionable whether treating survivors in a HIV CCC, (or indeed having a HIV CCC separate from other services), is the best way to attend to survivors and HIV patients. Facilities need to explore the best venues for providing treatment to survivors that do not subject them to stigma and consequently run the risk of missing HIV PEP and other services.
- 2) Training of staff on sexual violence management including how they can provide a suitable atmosphere for disclosure of violence is needed. Healthcare providers need to be trained not only on clinical management but also empathy, confidentiality and stigma reduction: areas identified by survivors as current challenges.
- 3) Children and adolescents constitute the majority of survivors being treated in hospitals, yet there are no services tailored to this group available. It is necessary to develop services that better address the special needs of children and adolescents. Specific guidelines and protocols for treating children and adolescents need to be developed and operationalised in order to provide quality services to this group of survivors. Guidelines on linkages with the child protection system and long term post-assault care should be developed. Moreover, clear guidelines and policy to allow adolescents to access sexual and reproductive health services, as part of the post-assault care, which are not dependent on parental consent should be developed.

8.4 PhD Contribution

This is the first study to exhaustively review existing evidence on CHWs services for sexual violence. It is also the first to document in-depth the survivors' perspectives on CHWs and the CHWs actual experiences with survivors.

This study collected data that illuminated the characteristics of those who fail to seek healthcare in Kenya and barriers to healthcare both at the community and hospital level. This is important to inform the design of interventions to improve access to healthcare and completion of treatment.

CHWs can provide an alternative model for support services for sexual violence survivors and this is being adopted in Kenya. This study provided relevant data on existing models of CHWs, the roles they play as well as the challenges and benefits of CHWs in sexual violence services. A focus on the experiences of CHWs and sexual violence survivors in real context of service delivery documented the different barriers and facilitators of CHWs service delivery and utilisation that is crucial for developing any effective interventions.

Overall, the findings have demonstrated that CHWs can play an important role in sexual violence care in Kenya with the ultimate aim of enhancing treatment seeking and completion, positive psychosocial outcomes and retention in care. The data is crucial as a baseline for developing best practice for CHWs services for sexual violence.

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Appendices

Appendix 1: Post rape care (PRC) form

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

PRC
Post Rape Care Form 

Date		Day		Month		Year		Province Code		District Code		OP/IP No.		PRC reg. No.									
Last Name				First Name				Date of birth		Day		Month		Year		<input type="checkbox"/> Male <input type="checkbox"/> Female							
Contacts (Residence and Phone number)												Marital Status (specify)											
Disabilities (Specify)												Orphaned vulnerable child (OVC)				Citizenship							
Date and time of Examination						Date and Time of Assault						No. of perpetrators											
Day		Month		Year		Hr		Min		AM		Day		Month		Year		Hr		Min		AM	
Alleged perpetrators (Indicate relation to victim)												<input type="checkbox"/> Male <input type="checkbox"/> Female		Estimated Age									
<input type="checkbox"/> Unknown <input type="checkbox"/> Known												Occupation of perpetrator											
Place Assault Occurred /Where incidence occurred																							
Administrative location																							
Chief complaints / Presenting Symptoms																							
Circumstances surrounding the incident (survivor account) remember to record penetration (how, where, what was used? Indication of struggle?)																							
Type of Assault		Use of condom?		Incident already reported to police?																			
<input type="checkbox"/> Oral		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No <input type="checkbox"/> Yes (indicate which police station)																			
<input type="checkbox"/> Vaginal		<input type="checkbox"/> No		Date and time of report						Day		Month		Year		Hr		Min		AM			
<input type="checkbox"/> Anal																							
<input type="checkbox"/> Other (specify)				Attended a health facility before this one?						Were you treated?		Were you given referral notes?											
				<input type="checkbox"/> No <input type="checkbox"/> Yes (Indicate name of facility)						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No											
				Date						Day		Month		Year		Hr		Min		AM			
Comments																							
Significant medical and/or surgical history																							

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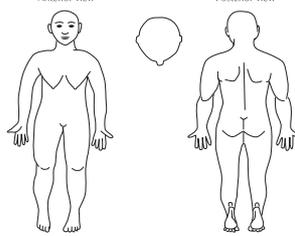
OB /GYN History	Parity	Contraception type	LMP	Known Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last consensual sexual intercourse
General Condition	BP	Pulse Rate	RR	Temp	Demeanor /Level of anxiety (calm, not calm)
Forensic					
Did the survivor change clothes?		State of clothes (stains, torn, color, where were the worn clothes taken)?			
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Were the clothes put in a non-plastic paper bag?		Were the clothes given to the police?			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Did the survivor have a bath?		Did the survivor go to the toilet?			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Long call? <input type="checkbox"/> Short call?			
Comments:					
Does the survivor have any details on the assailant? Is the assailant known, is there any relation? Did the survivor leave any marks on the assailant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Comments					
Genital Examination of the survivor-indicate discharges, inflammation, bleeding					
Describe in detail the physical status					
Physical injuries (sign in the body map)					
Outer genitalia					
Vagina					
Hymen					
Anus					
Other significant orifices					
Comments					
Immediate Management	PEP 1st dose <input type="checkbox"/> No <input type="checkbox"/> Yes (No of tablets)	ECP given <input type="checkbox"/> No <input type="checkbox"/> Yes	Stitching /surgical toilet done <input type="checkbox"/> No <input type="checkbox"/> Yes(Comment)	STI treatment given <input type="checkbox"/> No <input type="checkbox"/> Yes(Comment)	

MOH 363

Physical examination [indicates sites and nature of injuries, bruises and marks outside the genitalia]
Please use the sketches below to indicate injuries, inflammations, marks on various body parts of the survivor

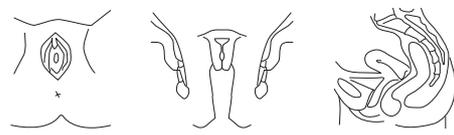
Sketch of person

Anterior view Posterior view

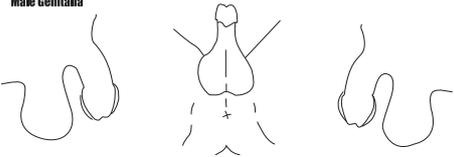


Comments

Female Genitalia



Male Genitalia



MOH 363

Any other treatment / Medication given/management?

Referrals to

Police Station HIV Test Laboratory
 Legal Trauma Counseling Safe Shelter
 OPD/CCC/HIV Clinic Other (specify)

Name of Examining Medical/Clinical/Nursing Officer

Signature of Examining Medical/Clinical/Nursing Officer

L	Sample Type	Test	Please tick as is applicable		Comments
			National government Lab	Health Facility Lab	
A	Outer Genital swab	Wet Prep Microscopy			
B	Anal swab	DNA			
O	Skin swab	Culture and sensitivity			
R	Oral swab	Specify			
A	High vaginal swab	Wet Prep Microscopy			
T	Urine	Pregnancy Test			
S	Blood	Microscopy			
A		Drugs and alcohol			
M		Other			
P		Haemoglobin			
L	Pubic Hair	DNA			
E	Nail clippings	DNA			
S	Foreign bodies	DNA			
	Other (specify)				

Chain of custody

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

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

Appendix 2: Survivors IDI guide (For survivors who sought healthcare)

Basic socio-demographic characteristics	
Age	
Gender	
Marital status	
Education	
Health facility	

Icebreaker: Tell me a little about yourself (what are your likes/dislikes, hobbies)

Discussion guide	Probes
<p>Experience with health services: I am going to ask you about the services you received after the unwanted sexual incidence. I would like to remind you that anything you say is strictly confidential. You are also free to stop me or not answer any question you are not comfortable with.</p>	
<p>Would you tell me what your experience was like when you went to the hospital?</p>	<p><i>When did you go to the hospital? What services did you receive? On the first day? Could you talk me through the process? How easy or hard was it to get the services? Why How did you find the services you received? (Satisfaction, what things/elements s/he liked, challenges) (If return visit) After the initial day, did you go back to the hospital? When? What happened then? Any other visits? How did the care you received at the hospital help you in dealing with your experience? In what ways? What support would you have wanted to continue receiving? How do you think the services could be improved? Did you receive any other services outside the hospital? What services? How did you get there? Who sent you there?</i></p>
<p>Attitude towards CHW services: I would now like us to talk about CHWs</p>	
<p>Tell me what you know about CHWs</p>	<p><i>Who do you think CHWs are? What do they do? What do other people in the community say about them? Who seeks CHW services? For what services? How accessible do you think CHWs are? Have you ever received any services from a CHW? Which services did you receive? How did you feel about the services?</i></p>
<p>Attitude towards CHW services for sexual violence:</p>	
<p>Have you talked to a CHW about the unwanted sexual incidence?</p>	<p><i>How did you feel about talking to a CHW? Was it easy or hard? What problems, if any, do you think might arise because you talked to a CHW about your experience? How else do you think a CHW can be useful to a person who has gone through a similar experience as you? If have not talked to a CHW, would you be willing to talk to one? Why? How do you think a CHW can assist you? In what ways? What problems, if any, do you think might arise if you talked to a CHW about your experience?</i></p>
<p>Healthcare seeking: Now I would like us to talk about what happened soon after the unwanted sexual incidence. I would like to remind you that you do not have to answer any question that you are uncomfortable with.</p>	
<p>Could you tell me a little about what happened soon after?</p>	<p><i>Did you talk to anyone? Who? What happened next? Was it easy or hard to talk to this person? What made it easy or hard? Did you talk to your family about the incidence? Who? Why?</i></p>

	<p><i>Did you talk to anyone outside your family? Who? Why?</i> <i>What were people's reactions?</i> <i>How did that reaction make you feel? Did that affect what you did next?</i> <i>Where else did you go before going to hospital?</i> <i>Where did you go to the hospital, why</i> <i>How long after the incidence did you seek care, why if delayed</i> <i>How long ago was the incidence? Where did it happen? Who was the perpetrator?</i> <i>What do other people in your community say about people who have gone through an experience like yours? Views (support them, encourage them to report and seek care, blame them)</i> <i>How has life changed since the incidence? How?</i> <i>Would you like me to refer you to talk to a counsellor or for any other services?</i></p>
<p>Follow-up visit questions: Thank you for agreeing to meet me again. Today we are going to talk about how you have been since we last talked. As with our last meeting, anything we talk about is strictly confidential. Remember you can also choose not to answer any of my questions that make you uncomfortable or stop the discussion at any time you like.</p>	
<p>1. Tell me how you have been doing since our last meeting</p>	<p><i>Tell me what has happened since we last met</i> <i>Have you noticed any changes in you since- physical, emotional -Any issues –STIs, pregnancy etc.</i></p>
<p>2. Have you talked to anyone about your experience?</p>	<p><i>Who? What did you discuss? How did you feel about the discussion?</i> <i>If not talked to anyone, why is that</i> <i>Have there been any changes in the way you relate to people? Any changes in how people relate to or treat you?</i></p>
<p>3. Have you been back to the hospital?</p>	<p><i>When was that?</i> <i>What happened at the hospital when you visited?</i> <i>Are you on any treatment? What drugs? What has been your experience with the drugs?</i> <i>If not, why not</i></p>
<p>4. Have you received any other support or services?</p>	<p><i>Have you sought help from any other organisations? Which ones? What happened there? Who sent you to the other organisation?</i> <i>Have you had any contact with the police? Tell me more</i> <i>What kind of support have you received from your family? And community?</i> <i>How did you find the support you received? What other support would you have wanted?</i> <i>Has the unwanted sexual incidence made your life change in any way? How?</i></p>

Conclusion

I would like to thank you very much for your time and for the information you have provided. I would also like to give you an opportunity to ask any questions that you may have now.

Finally, I would like to reemphasize what I said at the beginning of the interview, that all the information you have given is confidential.

Thank you

Appendix 3: Survivors IDI guide (For survivors who did not seek healthcare)

Basic socio-demographic characteristics	
Age	
Gender	
Marital status	
Education	
Health facility	

Icebreaker: Tell me a little about yourself (what are your likes/dislikes, hobbies)

Discussion guide	Probes
<p>Experience with services: I am going to ask you about the any services you received after the unwanted sexual incidence. I would like to remind you that anything you say is strictly confidential. You are also free to stop me or not answer any question you are not comfortable with.</p>	
<p>Would you tell me about any help/services you received?</p>	<p><i>If any, what was it? Who recommended it?</i> <i>What support have you received from your family? Community?</i> <i>What support have you received from the WKF? Could you talk me through the process?</i> <i>How did you hear of the WKF?</i> <i>How did you feel about the care you received from the WKF(satisfaction, what things/elements s/he liked, challenges)</i> <i>How did the care you received help you in dealing with your experience? In what ways?</i></p> <p><i>What are the reasons why you did not go to the hospital?</i> <i>What care would you have wanted at the hospital?</i> <i>What support would you have wanted to continue receiving?</i></p>
<p>Attitude towards CHW services: I would now like us to talk about CHWs</p>	
<p>Tell me what you know about CHWs</p>	<p><i>Who do you think CHWs are?</i> <i>What do they do?</i> <i>What do other people in the community say about them?</i> <i>Who seeks CHW services? What services?</i> <i>How accessible do you think CHWs are?</i> <i>Have you ever received any services from a CHW? Which services did you receive?</i> <i>How did you feel about the services?</i></p>
<p>Attitude towards CHW services for sexual violence:</p>	
<p>Have you talked to a CHW about the unwanted sexual incidence?</p>	<p><i>How did you feel about talking to a CHW? Was it easy or hard?</i> <i>What problems, if any, do you think might arise because you talked to a CHW about your experience?</i> <i>How else do you think a CHW can be useful to a person who has gone through a similar experience as you?</i></p> <p><i>If have not talked to a CHW, would you be willing to talk to one? Why?</i> <i>How do you think a CHW can assist you? In what ways?</i> <i>What problems, if any, do you think might arise if you talked to a CHW about your experience?</i></p>
<p>Help seeking: Now I would like us to talk about what happened soon after your experience of the unwanted sexual incidence. I would like to remind you that you do not have to answer any question you are uncomfortable with.</p>	
<p>Could you tell me a little about what happened soon after the</p>	<p><i>Did you talk to anyone? Who? What happened next?</i> <i>Was it easy or hard to talk to this person? What made it easy or hard?</i></p>

<p>incidence?</p>	<p><i>Did you talk to your family about the incidence? Who? Why?</i> <i>Did you talk to anyone outside your family? Who? Why?</i> <i>What were people's reactions?</i> <i>How did that reaction make you feel? Did that affect what you did next?</i> <i>How long after the incidence did you go to WKF?</i> <i>How long ago was the incidence? Where did it happen? Who was the perpetrator?</i> <i>What do other people in your community say about people who have gone through an experience like yours? Views (support them, encourage them to report and seek care, blame them)</i> <i>How has life changed the incidence? How?</i> <i>Would you like me to refer you to talk to a counsellor or for any other services?</i></p>
-------------------	--

Conclusion

I would like to thank you very much for your time and for the information you have provided. I would also like to give you an opportunity to ask any questions that you may have now.

Finally, I would like to reemphasise what I said at the beginning of the interview, that all the information you have given is confidential.

Thank you

Appendix 4. Health care workers IDI guide

Basic socio-demographics	
Age	
Gender	
Position	
Facility/organisation	

Icebreaker

Tell me about the services provided by this facility/organisation

Tell me about your role in this facility/organisation

Discussion guide	Probes
Experience with sexual violence services: I would like us to talk about the care available to persons who have experienced sexual violence	
1. How do sexual violence survivors get care?	<i>Who do they go to? Do they go to hospitals for care? Which hospitals do they go to? How do they get to the hospitals?</i>
2. Tell me about the survivors who come to this facility	<i>Who is mainly affected? (adults, children, women, men, boys, girls) Which types of survivors are more likely to come for care? Where do they come from? What type of sexual violence do they present with?</i>
3. Tell me about the services offered to sexual violence survivors in this facility/organisation	<i>What services are they offered here? (PEP, counselling etc.) Who is offered these services? Who offers them? Where are they offered? What challenges are experienced when delivering these services? How can these challenges be overcome?</i>
4. What type of follow-up is done once the survivor has been treated?	<i>After the initial visit, what are pathways of care for the survivor? What are you supposed to do as a healthcare worker? Are they referred elsewhere? Where? For what services? How are they referred? Do they come back? After how long? Any other visits? How long do they remain in care? What happens after that? What challenges are involved in follow up? How do you handle these challenges?</i>
Experience and attitudes towards CHWs: Now I would like us to talk about CHWs	
1. Tell me about your experience with CHWs	<i>Does the facility/organisation have CHWs, what are their roles?</i>
2. Tell me what services you think can be offered by CHWs to persons who have experienced sexual violence	<i>Do they play any roles in sexual violence care? What roles? Which services do you think can be offered by CHWs to sexual violence survivors, why Others (identification of survivors, psychosocial support, treatment monitoring, referral) What role do you think the CHW can play in reducing sexual violence stigma in the community?</i>
3. How effective do you think CHWs are in delivering health services?	<i>Effective or not, why What do you think are the barriers to CHWs being effective? How do CHWs provide feedback to this facility/ organisation? How do CHWs refer clients to this facility/organisation?</i>

	<i>How do you think CHWs services can be improved?</i>
<i>Additional views on the topic</i>	
In general, how do you think access to care, treatment adherence and retention in care can be improved for sexual violence survivors? Do you have any further comments or suggestions	

Conclusion

I would like to thank you very much for your time and for the information you have provided. I would also like to give you an opportunity to ask any questions that you may have now.

Finally, I would like to reemphasize what I said at the beginning of the interview, that all the information you have given is confidential.

Thank you

Appendix 5. CHWs IDI guide

Basic socio-demographics	
Participant code	
Age	
Gender	
Marital status	
Education	
Facility/organization	

Discussion guide	Probes
Experience of being a CHW:	
I would like us to start by talking a little about the work of CHWs	
1. Tell me about your experience being a CHW	<p><i>What do you do?</i></p> <p><i>How do you feel about being a CHW?</i></p> <p><i>Tell me about the area/number of clients you attend to?</i></p> <p><i>What do other people in the community say about CHWs?</i></p> <p><i>Which people seek services from CHWs?</i></p>
2. Tell me about the different conditions that you attend to	<p><i>What conditions do you encounter</i></p> <p><i>Are there some that are easier or harder to deal with (Which ones? Why)</i></p>
Attitude and experience with sexual violence services:	
Now I would like us to talk about services to persons who have experienced sexual violence	
1. What are your views on sexual violence?	<i>What do you think about persons who have experienced sexual violence?</i>
2. In this community, what typically happens when someone has experienced sexual violence?	<i>Who do they tell?</i>
3. What services are available for persons who have experienced sexual violence?	<p><i>Where do they go?</i></p> <p><i>For what services?</i></p>
4. Have you ever had to deal with someone who has experienced sexual violence?	<p><i>Tell me more about the first case you ever dealt with? What happened? What did you say? What did you do? Where did you send her?</i></p> <p><i>How did you feel dealing with this case? what went well, what did not go so well</i></p> <p><i>Were there any challenges that you experienced with it? How did you handle those challenges</i></p> <p><i>Tell me about the most recent case, how different was this experience from the first one, why is that</i></p> <p><i>If never dealt with a case, have you known of any cases? Did you ask/talk to the person you knew had experienced violence? If did not, why?</i></p> <p><i>What would you do if someone told you they have experienced sexual violence?</i></p> <p><i>How prepared do you feel in handling a sexual violence survivor based on your training? What support might be of further use to you to be more prepared to offer services to a sexual violence survivor?</i></p>
5. Tell me what you think of CHWs offering services to persons who have experienced sexual violence	<p><i>What do you think about dealing with a sexual violence survivor as a role for a CHW? Why?</i></p> <p><i>Do you think there are any advantages or disadvantages?</i></p> <p><i>Do you think there is anything that needs to be done for CHWs to be</i></p>

Appendices

	<p><i>able to offer services to persons who have experienced sexual violence? (e.g. training)</i></p> <p><i>Do you think there are any concerns? (e.g. safety)</i></p>
<p>6. Tell me what services you think can be offered by CHWs to persons who have experienced sexual violence</p>	<p><i>Which services do you think can be offered by CHWs? why</i></p> <p><i>Others (identification of survivors, psychosocial support, treatment monitoring, referral)</i></p>
<p>Community attitude towards sexual violence:</p> <p>Now I would like you tell me about the community where you come from</p>	
<p>What do other people in your community say about persons who have experienced sexual violence?</p>	<p><i>Views (support them, encourage them to report and seek care, blame them)</i></p> <p><i>How do you think sexual violence stigma can be reduced in the community?</i></p> <p><i>How do you think you could contribute to reduce sexual violence stigma in your role as a CHW?</i></p>
<p>Linkages with formal health services</p>	
<p>1. What has your experiences working with the health facility been like?</p>	<p><i>What support do you receive from the health facility?</i></p> <p><i>How do you feel about this support? (Adequate/not, why)</i></p> <p><i>What support do you think the facility can offer in regards to sexual violence? What procedure do you think you should follow with the health facility? Should you refer survivors? Should you follow up after you have referred? What else?</i></p> <p><i>How do you refer clients who need further help?</i></p> <p><i>What are some of the things that make it easy for you to do your work?</i></p> <p><i>What are some of the things that make it difficult to do your work?</i></p> <p><i>What do you think helps/would help you perform your job better?</i></p> <p><i>How else do you think the facility can support you?</i></p>

Conclusion

I would like to thank you very much for your time and for the information you have provided. I would also like to give you an opportunity to ask any questions that you may have now.

Finally, I would like to reemphasize what I said at the beginning of the interview, that all the information you have given is confidential.

Thank you

Appendix 6. Stakeholders Key Informant Interview Guide

Basic socio-demographics	
Age	
Gender	
Position	
Facility/organization	

Icebreaker

Tell me about the services provided by this facility/organisation

Tell me about your role in this facility/organisation

Discussion guide	Probes
Experience with sexual violence services:	
I would like us to start by talking about the services available for persons who have experienced sexual violence	
1. How do sexual violence survivors get care?	<i>Who do they go to? Do they go too hospitals for care? Which hospitals do they go to? What services do they get? What services should they get?</i>
2. Tell me about the services offered to sexual violence survivors in this facility/organisation	<i>What are the services offered here/ by your organisation? Who offers them? How are these services organised/delivered? What challenges are experienced when delivering these services? How can these challenges be overcome?</i>
Experience and attitudes towards CHWs:	
Now I would like us to talk about CHWs	
1. Tell me about your experience with CHWs	<i>Does the facility/organisation have CHWs? What are their roles? How do CHWs provide feedback to this facility/ organisation? How do CHWs refer clients to this facility/organisation?</i>
2. How effective do you think CHWs are in delivering health services?	<i>Effective or not, why? What do you think are the barriers to CHWs being effective? How do you think CHWs services can be improved? What support should the health facility offer to them? Why?</i>
Attitude towards CHW services for sexual violence	
Now I would like us to talk about CHWs offering services to persons who have experienced sexual violence	
1. What do you think of CHWs offering services to persons who have experienced sexual violence?	<i>Feel comfortable/not comfortable about it, why? Do you think there are any advantages or disadvantages? What are their needs in your opinion for them to offer services? (E.g. training) In your opinion, do you think there are any concerns? (E.g. safety) What are your thoughts on the Ministry of Health inclusion of some sexual violence services among CHWs responsibilities? Have you been involved in implementation? Any challenges/successes?</i>
2. What services do you think can be offered by CHWs to persons who have experienced sexual violence?	<i>Which services do you think can be offered by CHWs, why? Others (identification of survivors, psychosocial support, treatment monitoring, referral) What role do you think the CHW can play in reducing sexual violence stigma in the community?</i>
Additional views on the topic	
In general, how do you think access to care, treatment adherence and retention in care can be improved for sexual violence survivors?	

Do you have any further comments or suggestions (including other stakeholders to interview)

Conclusion

I would like to thank you very much for your time and for the information you have provided. I would also like to give you an opportunity to ask any questions that you may have now.

Finally, I would like to reemphasize what I said at the beginning of the interview, that all the information you have given is confidential.

Thank you

Appendix 7: Study approval

7.1 Approval from LSHTM

London School of Hygiene & Tropical Medicine
 Keppel Street, London WC1E 7HT
 United Kingdom
 Email: ethics@lshtm.ac.uk +44 (0)20 7636 5636
www.lshtm.ac.uk



Observational / Interventions Research Ethics Committee

LSHTM

21 July 2015 21 July 2015

Dear .

Study Title: Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors

LSHTM ethics ref: 9896

Thank you for your application for the above research, which has now been considered by the Observational Committee.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Committee suggestion: The committee suggests that the information sheet and consent forms are separated into two separate documents. The committee also suggests that each item on the consent form has its own check box and that the point about additional approval being sought for use of quotations is made a separate point on the form.

Conditions of the favourable opinion

Approval is dependent on local ethical approval having been received, where relevant.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type	File Name	Date	Version
Protocol / Proposal	28 06 2015_Pathways of care for sexual violence survivors and the role of community health workers	28/06/2015	1
Protocol / Proposal	28 06 15_A systematic review of models of community health worker (CHW) services for treating sequelae of sexual violence	28/06/2015	1
Protocol / Proposal	28 06 2015_Study Tools	28/06/2015	1
Investigator CV	28 06 2015_AG_LSHTM Ethics Online CV	28/06/2015	1
Information Sheet	28 06 2015_Study information and consent forms	28/06/2015	1

After ethical review

The Chief Investigator (CI) or delegate is responsible for informing the ethics committee of any subsequent changes to the application. These must be submitted to the Committee for review using an Amendment form. Amendments must not be initiated before receipt of written favourable opinion from the committee.

The CI or delegate is also required to notify the ethics committee of any protocol violations and/or Suspected Unexpected Serious Adverse Reactions (SUSARs) which occur during the project by submitting a Serious Adverse Event form.

At the end of the study, the CI or delegate must notify the committee using an End of Study form.

All aforementioned forms are available on the ethics online applications website and can only be submitted to the committee via the website at: <http://leo.lshtm.ac.uk>

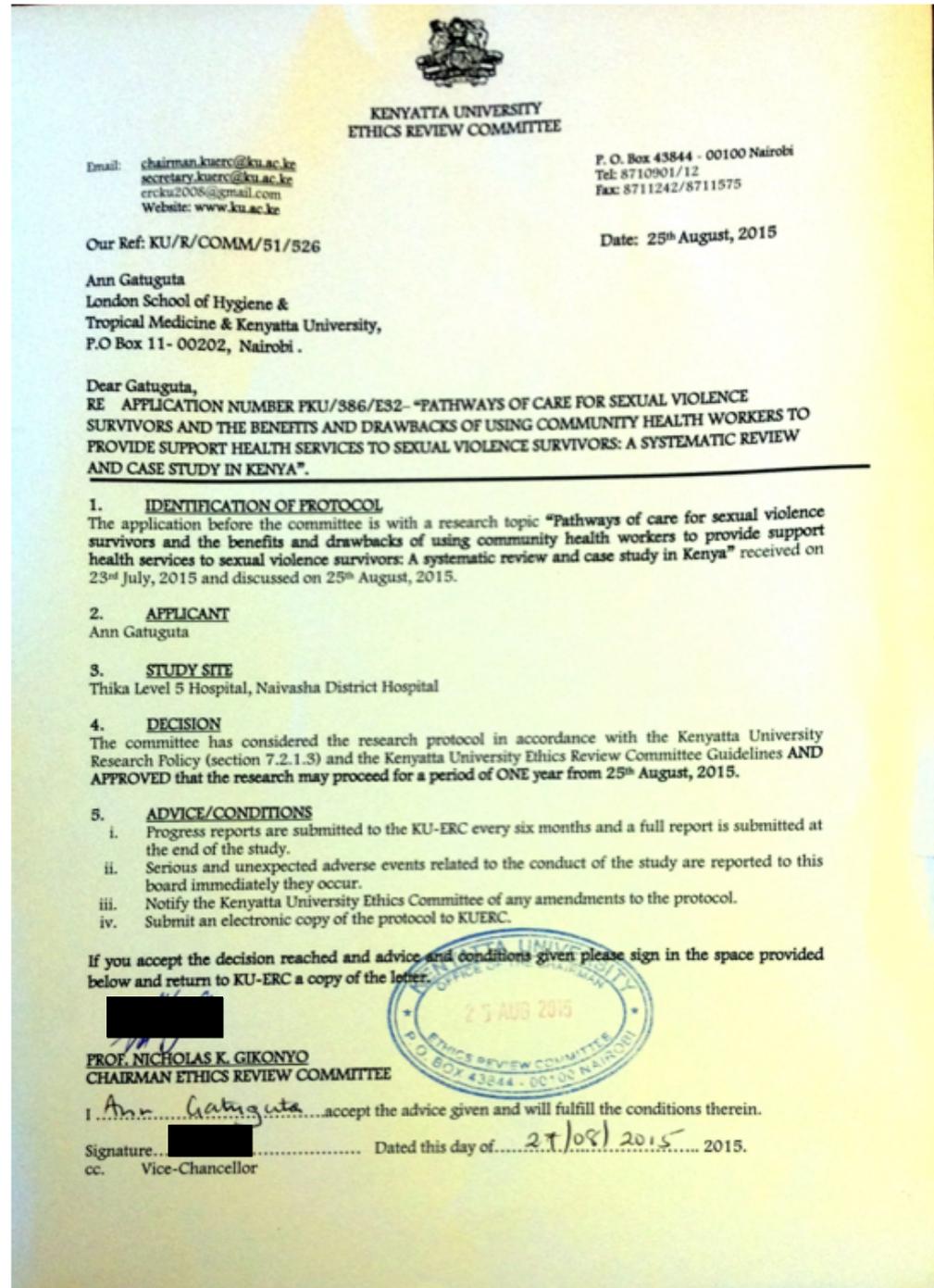
Additional information is available at: www.lshtm.ac.uk/ethics

Yours sincerely,



Page 1 of 2

7.2 Approval from Kenyatta University



7.3 Approval from Kiambu County

**MINISTRY OF HEALTH
KIAMBU COUNTY**

Telegrams: "MEDICAL", Kiambu
Telephone : Kiambu (office) 2011051
When replying please quote
Mobile: 0721276644
Email address: cdhkiambu@gmail.com



CHIEF OFFICER – HEALTH SERVICES
P. O. BOX 2344 – 00900
KIAMBU

Ref. No.: KBU/COUNTY/RESEARCH AUTHO/VOL 1/27

Date: 04th September, 2015

TO WHOM IT MAY CONCERN,

RE: CLEARANCE TO CONDUCT RESEARCH IN THE COUNTY

Kindly note that we have received a request by Dr Anne Gatuguta of Kenyatta University to conduct research on ***“Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors: A systematic review and case study in Kenya”*** in Kiambu County.

We have duly inspected the study documentation and found that it has been cleared by the Kenyatta University ERC to proceed during 25th August 2015 – 25th August 2016. There is thus no need for further clearance with another regulatory body in order to conduct research within the county of Kiambu, and the County Health Research and Development Unit has no objection to this study proceeding as proposed.

However, it is incumbent upon the facility in which the research is being carried out to ensure that they are conversant with the remit of the study and operate in line with their institutional norms on conducting research. This note also accords the principal investigator the duty to provide feedback on the research to the county at the conclusion of the study.



Dr M. N. Ndirangu, MBChB, Mphil, CRD
County Health Research & Development Unit,
KIAMBU COUNTY

7.4 Approval from Thika Level 5 Hospital

MINISTRY OF HEALTH

Tel: Thika 067 21621/2 fax 21778
All correspondence should be addressed to
MED.SUPT.
When replying please quote



THIKA LEVEL 5 HOSPITAL
P.O. BOX 227
THIKA

Ref: NO. MOMS/TKA/01 III (326)

Date: 6th September, 2015

APPROVAL TO CARRY OF RESEARCH

Principle investigator: Dr. Ann Gatuguta

Research topic: **A STUDY ON THE PATHWAYS OF CARE FOR SEXUAL VIOLENCE SURVIVORS AND BENEFITS AND DRAWBACKS OF USING COMMUNITY HEALTH WORKERS TO PROVIDE SUPPORT HEALTH SERVICES TO SEXUAL VIOLENCE SURVIVORS; A SYSTEMATIC REVIEW AND CASE STUDY IN KENYA.**

Following deliberations by Thika Level 5 hospital research committee, your proposal to carry out the above research here has been approved.

Take note that you are required to submit a copy of your research findings upon completion of the study to the hospital. It is also expected that the Ethical consideration and the research subjects confidentiality will be maintained as you have outlined in your proposal.

This letter is valid until ~~June~~ 30th June, 2016.

Any patient confidential information that you may access during your research should not be used without consent.

For any queries feel free to contact the committee chair through the Medical Superintendent's office.

Thank you and all the best.


DR. MBOGO
CHAIR THE TREC
THIKA LEVEL 5 HOSPITAL

7.5 Approval from Nakuru County



Appendix 8: Study information sheet and consent forms**8.1 Sexual violence survivor information sheet and informed consent****Sexual violence survivor information sheet**

Title of Project: Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors: A systematic review and case study in Kenya

Introduction

Good morning/afternoon. My name is.....and I would like to first thank you for agreeing to meet with me. I am from the London School of Hygiene and Tropical Medicine and we are conducting a study on health services for people who have experienced an unwanted sexual incidence. We are asking you to be in this study. This form provides you with information about the study so that you can decide whether you want to participate or not. After you have listened to this information you may ask questions about the study, what you are expected to do and anything else that is not clear to you.

Purpose of the study

This study is aimed at collecting information that would help improve health services for people who have experienced an unwanted sexual incidence. Specifically, we want to find out what services you wanted after your experience, which services you received and your thoughts about these services. We will also ask for your views on the services that CHWs can or could have offered you and ways these services can be delivered. The information you give us will be used to recommend ways to make it easier for people who have experienced an unwanted sexual incidence to access healthcare. We will be talking to other people on the same topic and we will use information from all the interviews to come up with recommendations.

If you decide to take part

I will request you to be interviewed and this interview will take about one hour. During this interview, I will ask about what happened after the incidence, the

services you received and your experience with CHWs. I will ask for your permission to allow the interview to be recorded so that the information you provide will be captured accurately and I do not have to write everything. You may request for the recording to be stopped at any time.

Confidentiality

The interview is strictly private. Any information you give will not be shared with anyone else and our records and report will not contain your name. All the information collected and recorded will be kept in a locked cabinet and no one else will have access to it. We will keep any quotations that we use in our report or other publications from your interview anonymous and ask for your permission prior to using them. You are free to stop the interview at any time or not answer any questions you feel uncomfortable with. There is no right or wrong answer; we are interested in your opinion so you can talk freely.

Risks and benefits

If talking about your experience is uncomfortable, you may stop me at any time. There are no direct benefits to you. However, the information you give will be used to recommend ways for improving health services for other people have experienced an unwanted sexual incidence. Kenya shillings 500 will be given to you to compensate you for your time and the transport fare you have used to come for this interview.

Permission for re-contact

With your permission, I might contact you again in future to see how you are doing, and if anything has changed. Of course, you can change your mind about this at any time and you do not have to speak to me if you don't want to.

Problems or questions

If you have any questions about this study, please contact Anne Gatuguta on telephone number +254725962738. If you have questions about your rights as a research participant, you should contact the chairman of the Kenyatta University ethics committee on telephone: (020) 8704390

Sexual violence survivor consent form

Title of Project: Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors: A systematic review and case study in Kenya

Name of investigator: Anne Gatuguta

		Please initial each box
1	I confirm that I have read and understand the participant information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered fully.	
2	I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.	
3	I understand that sections of my medical notes and data collected during the study may be looked at by responsible individuals from the London School of Hygiene & Tropical Medicine, from regulatory authorities or from this hospital, where it is relevant to my taking part in this research. I give permission for these individuals to access my records.	
4	I agree for my quote to be used in the publication or report released on the study once my permission has been sought and I have agreed.	
5	I agree to take part in the above study.	

Participant's signature: _____

Date: _____

Researcher's Signature: _____

Date: _____

8.2 CHW information sheet and informed consent

Community health worker information sheet

Title of Project: Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors: A systematic review and case study in Kenya

Introduction

Good morning/afternoon. My name is.....and I would like to first thank you for agreeing to meet with me. I am from the London School of Hygiene and Tropical Medicine and we are conducting a study on health services for people who have experienced sexual violence. We are asking you to be in this study. This form provides you with information about the study so that you can decide whether you want to participate or not. After you listened to this information you may ask questions about the study, what you are expected to do and anything else that is not clear to you.

Purpose of the study:

This study is aimed at collecting information that would help improve health services for people who have experienced sexual violence. Specifically, we want to find out the services available to sexual violence survivors, the services that CHWs can offer, ways these services can be delivered and how best to support those who deliver services to community members who have experienced sexual violence. The information you give us will be used to recommend ways to make it easier for people who have experienced sexual violence to access healthcare. We will be talking to other people on the same topic and we will use information from all the interviews to come up with recommendations.

If you decide to take part

I will request you to be interviewed and this interview will take about one hour. During this interview, I will ask about the services available for people who have experienced sexual violence and your experience working with people who have experienced sexual violence. I will ask for your permission to allow the interview to be recorded so that the information you provide will be captured accurately and I

do not have to write everything. You may request for the recording to be stopped at any time.

Confidentiality

The interview is strictly confidential. Any information you give will not be shared with anyone else and our records and report will not contain your name. All the information collected and recorded will be kept in a locked cabinet and no one else will have access to it. We will keep any quotations that we use in our report or other publications from your interview anonymous and ask for your permission prior to using them. You are free to stop the interview at any time or not answer any questions you feel uncomfortable with. There is no right or wrong answer, we are interested in your opinion so you can talk freely.

Risks and benefits

There are no risks to you for taking part in this study. There are also no direct benefits to you. However, the information you give will be used to recommend ways for improving health services for people who have experienced sexual violence and support provided to CHWs who provide sexual violence services. You will not receive any payment for participating. Kenya shillings 500 will be given to you to compensate you for your time and the transport fare you have used to come for this interview.

Problems or questions

If you have any questions about this study, please contact Anne Gatuguta on telephone number +254725962738. If you have questions about your rights as a research participant, you should contact the chairman of the Kenyatta University ethics committee on telephone: (020) 8704390

Community Health worker consent form

Title of Project: Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors: A systematic review and case study in Kenya

Name of investigator: Anne Gatuguta

		Please initial each box
1	I confirm that I have read and understand the participant information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered fully.	
2	I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.	
3	I agree for my quote to be used in the publication or report released on the study once my permission has been sought and I have agreed.	
4	I agree to take part in the above study.	

Participant's signature: _____

Date: _____

Researcher's Signature: _____

Date: _____

8.3 Stakeholder/healthcare worker information sheet and informed consent

Stakeholder/ healthcare worker information sheet

Title of Project: Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors: A systematic review and case study in Kenya

Introduction

Good morning/afternoon. My name is.....and I would like to first thank you for agreeing to meet with me. I am from the London School of Hygiene and Tropical Medicine and we are conducting a study on health services for people who have experienced sexual violence. We are asking you to be in this study. This form provides you with information about the study so that you can decide whether you want to participate or not. After you have read or listened to this information you may ask questions about the study, what you are expected to do and anything else that is not clear to you.

Purpose of the study

This study is aimed at collecting information that would help improve health services for people who have experienced sexual violence. Specifically, we are looking to understand the pathways to care and the benefits and drawbacks of using community health workers to provide support services for sexual violence survivors. The information you give us will be used to make recommendations for feasible and acceptable CHW services in sexual violence care. We will be talking to other people on the same topic and we will use information from all the interviews to come up with recommendations.

If you decide to take part

You will be requested to be interviewed and this interview will take about one hour. During this interview, you will be asked about your experience with CHWs and sexual violence survivors' healthcare services. You will also be asked about which services you think CHWs can offer to sexual violence survivors. You will be asked for your permission to allow the interview to be recorded so that the information you

provide will be captured accurately and the interviewer does not have to write everything. You may request for the recording to be stopped at any time.

Confidentiality

The interview is strictly confidential. Any information you give will not be shared with anyone else and our records and report will not contain your name. All the information collected and recorded will be kept in a locked cabinet and no one else will have access to it. We will keep any quotations that we use in our report or other publications from your interview anonymous and ask for your permission prior to using them. You are free to stop the interview at any time or not answer any questions you feel uncomfortable with. There is no right or wrong answer, we are interested in your opinion so you can talk freely.

Risks and benefits

There are no risks to you in taking part in this study. There are also no direct benefits to you. However, the information you give will be used to recommend ways for improving health services for sexual violence survivors. You will not receive any payment for participating. However, Ksh 1,000 will be given to you to compensate you for your time and the transport fare you have used to come for this interview.

Permission for re-contact:

With your permission, I might contact you again in future, to seek your views and opinions on the study findings as well as the recommendations that will come up from the study. Of course, you can change your mind about this at any time and you do not have to speak to me if you don't want to.

Problems or questions:

If you have any questions about this study, please contact Anne Gatuguta on telephone number +254725962738. If you have questions about your rights as a research participant, you should contact the chairman of the Kenyatta University ethics committee on telephone: (020) 8704390

Healthcare worker/Stakeholder consent form

Title of Project: Pathways of care for sexual violence survivors and the benefits and drawbacks of using community health workers to provide support health services to sexual violence survivors: A systematic review and case study in Kenya

Name of investigator: Anne Gatuguta

		Please initial each box
1	I confirm that I have read and understand the participant information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered fully.	
2	I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.	
3	I agree for my quote to be used in the publication or report released on the study once my permission has been sought and I have agreed.	
4	I agree to take part in the above study.	

Participant's signature: _____

Date: _____

Researcher's Signature: _____

Date: _____

Appendix 9: Database Search Strategy

Database	Domain	Search terms	No. of studies	
Ovid MEDLINE	1 Community health worker	Keyword search	community health worker* or CHW* or lay health worker* or community own resource person* or CORP* or patient advocate* or close to community health worker* or community health aide* or village health worker*	124,669
	2	Subject heading search	Exp community health workers/	3,608
	3 1 or 2			124,669
	4 Sexual violence	Keyword search	Sexual violence or sexual abuse or sexual molestation or sexual assault or rape or date rape or defilement or incest or sodomy or child sexual abuse or post exposure prophylaxis or PEP or ARV* or antiretroviral* or HIV PEP or nPEP or n-PEP	80,492
	5	Subject heading search	exp sexual offenses/ or exp child abuse, sexual/ or exp rape/ or exp Anti-Retroviral Agents/ or exp Antiretroviral Therapy, Highly Active/ or exp Anti-HIV Agents/ or exp Post-Exposure Prophylaxis/	91,886
	6 4 or 5			124,473
	7 3 and 6			404
Africa Wide Information				
	1 Community health worker	Keyword search	community health worker* or CHW* or lay health worker* or community own resource person* or CORP* or patient advocate* or close to community health worker* or community health aide* or village health worker*	65,041
	2	Subject heading search		
	3 1 or 2			65,041
	4 Sexual violence	Keyword search	Sexual violence or sexual abuse or sexual molestation or sexual assault or rape or date rape or defilement or incest or sodomy or child sexual abuse or post exposure prophylaxis or PEP or ARV* or antiretroviral* or HIV PEP or nPEP or n-PEP	25,063
	5	Subject heading search		
	6 4 or 5			25,063
	7 3 and 6			480
CINAHL Plus				
	1 Community health worker	Keyword search	community health worker* or CHW* or lay health worker* or community own resource person* or CORP* or patient advocate* or close to community health worker* or community health aide* or village health worker*	15,431
	2	Subject heading search	(MH "Community Health Workers")	1,516
	3 1 or 2			15,431

Appendices

	4	Sexual violence	Keyword search	Sexual violence or sexual abuse or sexual molestation or sexual assault or rape or date rape or defilement or incest or sodomy or child sexual abuse or post exposure prophylaxis or PEP or ARV* or antiretroviral* or HIV PEP or nPEP or n-PEP	22,903
	5		Subject heading search	(MH "Child Abuse, Sexual") OR (MH "Sexual Abuse+") OR (MH "Antiretroviral Therapy, Highly Active") OR (MH "Anti-Retroviral Agents") OR (MH "Anti-HIV Agents") OR (MH "Postexposure Follow-Up")	19,917
	6	4 or 5			24,412
	7	3 and 6			87
Cochrane Library					
	1	Community health worker	Keyword search	community health worker* or CHW* or lay health worker* or community own resource person* or CORP* or patient advocate* or close to community health worker* or community health aide* or village health worker*	5,339
	2		Subject heading search	Community Health Workers	239
	3	1 or 2			5,339
	4	Sexual violence	Keyword search	Sexual violence or sexual abuse or sexual molestation or sexual assault or rape or date rape or defilement or incest or sodomy or child sexual abuse or post exposure prophylaxis or PEP or ARV* or antiretroviral* or HIV PEP or nPEP or n-PEP	11,295
	5		Subject heading search (exp tree)	Child abuse, Sex offenses, Antiretroviral Therapy, Highly Active, post-exposure prophylaxis, Anti-retroviral	5,552
	6	4 or 5			12,785
	7	3 and 6			168
Embase					
	1	Community health worker	Keyword search	community health worker* or CHW* or lay health worker* or community own resource person* or CORP* or patient advocate* or close to community health worker* or community health aide* or village health worker*	205,085
	2		Subject heading search	Exp community care/ or exp health auxiliary/	107,048
	3	1 or 2			309,946
	4	Sexual violence	Keyword search	Sexual violence or sexual abuse or sexual molestation or sexual assault or rape or date rape or defilement or incest or sodomy or child sexual abuse or post exposure prophylaxis or PEP or ARV* or antiretroviral* or HIV PEP or nPEP or n-PEP	120,249
	5		Subject heading search	exp sexual abuse/ or exp sexual violence/ or exp rape/ or exp highly active antiretroviral therapy/ or exp antiretrovirus agent/ or exp post exposure prophylaxis	176,975
	6	4 or 5			223,619
	7	3 and 6			2,548
Global Health					

Appendices

	1	Community health worker	Keyword search	community health worker* or CHW* or lay health worker* or community own resource person* or CORP* or patient advocate* or close to community health worker* or community health aide* or village health worker*	18,472
	2		Subject heading search	(community health or community health services).sh.	5,948
	3	1 or 2			23,721
	4	Sexual violence	Keyword search	Sexual violence or sexual abuse or sexual molestation or sexual assault or rape or date rape or defilement or incest or sodomy or child sexual abuse or post exposure prophylaxis or PEP or ARV* or antiretroviral* or HIV PEP or nPEP or n-PEP	40,188
	5		Subject heading search	("rape (trauma)" or sexual abuse or antiretroviral agents or highly active antiretroviral therapy).sh.	22,380
	6	4 or 5			40,188
	7	3 and 6			233
PSYCHInfo					
	1	Community health worker	Keyword search	community health worker* or CHW* or lay health worker* or community own resource person* or CORP* or patient advocate* or close to community health worker* or community health aide* or village health worker*	36,759
	2		Subject heading search	exp Community Services/	27,122
	3	1 or 2			63,473
	4	Sexual violence	Keyword search	Sexual violence or sexual abuse or sexual molestation or sexual assault or rape or date rape or defilement or incest or sodomy or child sexual abuse or post exposure prophylaxis or PEP or ARV* or antiretroviral* or HIV PEP or nPEP or n-PEP	41,043
	5		Subject heading search	exp Sexual Abuse/ or exp Sex Offenses/ or exp Rape/ or exp Antiviral Drugs/	31,424
	6	4 or 5			45,771
	7	3 and 6			697
				Total (all row 7's)	4,617

Appendix 10: Methodological quality rating of quantitative studies

1. Quality rating pre-post test study (EPHPP checklist)

Rating domain	Rating scale	Barron, 2013 [134]
A) Selection bias		
Are the individuals selected to participate in the study likely to be representative of the target population?		Not likely
What percentage of selected individuals agreed to participate?		100%
Section rating	Strong, Moderate or Weak	Moderate
B) Study design		
Indicate the study design Was the study described as randomized? No/Yes If Yes, was the method of randomization described? No/Yes If Yes, was the method appropriate? No/Yes		Pre- posttest waitlist No
Section rating	Strong, Moderate or Weak	Moderate
C) Confounders		
Were there important differences between groups prior to the intervention?		Yes: Sex, age
If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?		Can't tell
Section rating	Strong, Moderate or Weak	Weak
D) Blinding		
Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?		Yes
Were the study participants aware of the research question?		Can't tell
Section rating	Strong, Moderate or Weak	Weak
E) Data collection methods		
Were data collection tools shown to be valid?		Yes
Were data collection tools shown to be reliable?		Can't tell
Section rating	Strong, Moderate or Weak	Moderate
F) Withdrawals and dropouts		
Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?		Yes
Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).		100%
Section rating	Strong, Moderate or Weak	Strong
G) Intervention integrity		
What percentage of participants received the allocated intervention or exposure of interest?		100%
Was the consistency of the intervention measured?		Yes
Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?		Can't tell
Section rating	Strong, Moderate or Weak	Moderate
H) Analyses		
Indicate the unit of allocation		Individual
Indicate the unit of analysis		Individual
Are the statistical methods appropriate for the study design?		Yes

Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?		Can't tell
Section rating	Strong, Moderate or Weak	Moderate

2. Quality rating of longitudinal study (QATSO Scale)

	Domain		Scoring	Kohli, 2012 [40]
1	Was the sampling method representative of the population intended to the study?	A. Non-probability sampling (including: purposive, quota , convenience and snowball sampling)	0	√
		B. Probability sampling (including: simple random, systematic, stratified g, cluster, two-stage and multi-stage sampling)	1	
2	Was the measurement of outcome objective)?	By questionnaires (Self-reported)	0	√
		By clinical records or lab tests	1	√
		Not applicable	NA	
3	Did the study report any response rate?	No	0	
		Yes	1	
		Not applicable	NA	√
4	Did the investigator(s) control for confounding factors (e.g. stratification/ matching/ restriction/ adjustment) when analysing the associations (if the study contains purely descriptive results, no association and prediction tests were conducted in the test, please select "Not applicable")?	No	0	
		Yes	1	
		Not applicable	NA	√
5	Was privacy or sensitivity of the nature of condition (sexual violence) considered when the survey was conducted e.g. if conducted in a general clinic setting?	No	0	
		Yes	1	√

Scoring method: Total score divided by total number of all applicable items

Grading of the QATSO score:

0% -33%	33%- 66%	67% -100%
Bad	Satisfactory	Good

Appendix 11: Methodological quality assessment for qualitative studies

		Barron, 2013 [134]	Itzhaky, 2001 [135]	Merkin, 1995 [136]	Rossmann, 1999 [137]	Tanabe, 2013 [65]	Zraly, 2011 [138]
Section 1: theoretical approach 1.1 Is a qualitative approach appropriate?	Appropriate	√	√	√	√	√	√
	Inappropriate						
	Not sure						
1.2 Is the study clear in what it seeks to do?	Clear	√				√	
	Unclear				√		
	Mixed		√	√			√
Section 2: study design 2.1 How defensible/ rigorous is the research design/ methodology?	Defensible	√	√			√	√
	Not defensible			√	√		
	Not sure						
Section 3: data collection 3.1 How well was the data collection carried out?	Appropriate	√	√			√	√
	Inappropriate						
	Not sure/ inadequately reported			√	√		
Section 4: validity 4.1 Is the context clearly described?	Clear	√	√			√	√
	Unclear			√	√		
	Not sure						
4.2 Were the methods reliable?	Reliable	√	√				
	Unreliable			√	√	√	√
	Not sure						
Section 5: analysis 5.1 Are the data 'rich'?	Rich	√				√	
	Poor			√			
	Not sure/not reported		√		√		√
5.2 Is the analysis reliable?	Reliable						
	Unreliable					√	√
	Not sure/not reported	√	√	√	√		
5.3 Are the findings convincing?	Convincing	√				√	√
	Not convincing		√	√	√		
	Not sure						
5.4 Are the conclusions adequate?	Adequate	√	√	√	√	√	√
	Inadequate						
	Not sure						
Section 6: ethics 6.1 Was the study approved by an ethics committee?	Yes	√				√	√
	No						
	Not sure/not reported/ not applicable		√	√	√		
6.2 Is the role of the researcher clearly described?	Clear	√				√	√
	Not clear		√	√			
	Not sure/not reported				√		
Section 7: Overall assessment	++	√				√	√

As far as can be ascertained from the paper, how well was the study conducted?	+		√				
	-			√	√		

Appendix 12: Measures generated to compare experiences with sexual violence across the Kenya Violence against Children Survey (VACS) 2010, the Kenya Demographic and Health Survey (DHS) 2014, and data collected from two hospitals in Kenya

Dataset	Questionnaire items	Coding
VACS 2010		
Any experience of sexual violence	How many times in your life... (1)...has anyone touched you in a sexual way without your consent, but did not try to force you to have sex? (2)...has anyone tried to make you have sex against your will but did not succeed? (3)...have you been physically forced to have sex against your will and sexual intercourse was completed? (4)...has someone pressured you to have sex when you did not want to and sex happened?	Coded 1 if answered '1 or more time' to any of the items; 0 if answered '0 times' to all items.
Marital status	Are you currently married or living with someone as if married? Have you ever been married or lived with someone as if married?	Coded 1 if married/living with someone as if married; coded 2 if formerly married/lived with someone as if married; coded 3 if answering 'No' to both questions.
Perpetrator known?	<i>For each of the four forms of sexual violence addressed (above):</i> Did you know any of the people who did this to you?	Coded 1 if answered 'Yes' for any of the forms of violence; 0 if answered 'No' to all forms of violence.
Relationship of perpetrator to survivor	<i>For each of the four forms of sexual violence addressed (above):</i> Were any of the people...(a) a boyfriend/romantic partner? (b) a husband? (c) a father? (d) a mother? (e) a brother? (f) a sister? (g) an uncle? (h) an aunt? (i) another male relative? (j) another female relative? (k) a teacher? (l) police? (m) military? (n) an employer? (o) a neighbour? (p) a community elder? (q) a religious leader?	Coded 1 if answered 'Yes' for a given perpetrator across any of the forms of violence; 0 if answered 'No' for a given perpetrator across all forms of violence. Perpetrator categories regrouped to align with other datasets.
Place where violence occurred	<i>For each of the four forms of sexual violence addressed (above):</i> Now think about the most recent time [this happened]? Where were you when this incident happened? (a) my home; (b) perpetrator's home; (c) someone else's home; (d) party; (e) public event; (f) school; (g) car/bus; (h) traveling by foot; (i) other location.	Coded 1 if answered 'Yes' for a given location across any of the forms of violence; 0 if answered 'No' for a given location across all forms of violence. Location categories regrouped to align with other datasets.
DHS 2014		
Any experience of sexual violence	(1) Does/did your (last) partner ever do any of the following things to you...(a) physically force you to have sexual intercourse with him/her even when you did not want to? (b) physically force you to perform any other sexual acts you did not want to? (c) force	Coded 1 if answered 'Yes' to any of the items; 0 if answered 'No' to all items.

	<p>you with threats or in any other way to perform sexual acts you did not want to?</p> <p>(2) Did any previous partner physically force you to have intercourse or perform any other sexual acts against your will?</p> <p>(3) At any time in your life, as a child or as an adult, has anyone [other than a partner] ever forced you in any way to have sexual intercourse or perform any other sexual acts?</p>	
Marital status	<p>Are you currently married or living with a man/woman? Are you formerly married/did you live with a man/woman [in the past]? Have you never been married/have you never lived with a man/woman?</p>	<p>Coded 1 if married/living with a man/woman; coded 2 if formerly married/lived with a man/woman; coded 3 if never married (i.e. single).</p>
Relationship of perpetrator to survivor	<p>(1) Does/did your (last) partner ever do any of the following things to you...(a) physically force you to have sexual intercourse with him/her even when you did not want to? (b) physically force you to perform any other sexual acts you did not want to? (c) force you with threats or in any other way to perform sexual acts you did not want to?</p> <p>(2) Did any previous partner physically force you to have intercourse or perform any other sexual acts against your will?</p> <p>(3) At any time in your life, as a child or as an adult, has anyone [other than a partner] ever forced you in any way to have sexual intercourse or perform any other sexual acts?</p>	<p>Coded 1 for "Current/previous partner" if answered 'Yes' to questions 1a, 1b, 1c or 2; coded 2 for "Other" if answered 'Yes' to question 3.</p>
Dataset	Questionnaire items	Coding
Hospital Survey		
Any experience of sexual violence	<p>N/A (participant included as having experienced sexual violence if a post-rape care form had been completed for the individual)</p>	N/A
Marital status	<p>Specify your marital status (open response).</p>	<p>Coded 1 if married/living with someone; coded 2 if formerly married/lived with someone; coded 3 if single.</p>
Perpetrator known?	<p>Were the alleged perpetrators (indicate relation to victim): Unknown or Known (check one box).</p>	<p>Coded 1 if ticked "Known"; 0 if ticked "Unknown".</p>
Relationship of perpetrator to survivor	<p>Does the survivor have any details on the assailant? Is the assailant known, is there any relation? (open response)</p>	<p>Coded 1 if a father/stepfather; coded 2 if a brother/stepbrother; coded 3 if a cousin; coded 4 if an uncle; coded 5 if another relative; coded 6 if an in-law; coded 7 if a neighbour; coded 8 if a friend/acquaintance/classmate; coded 9 if a family friend/friend to friend; coded 10 if a teacher; coded 11 if a stranger; coded 12 if a boyfriend/girlfriend; coded 13 if an ex-husband/ex-partner; coded 14 if a current husband/partner; coded 15 if a boyfriend but not considered coerced by the child; coded 16 if other.</p>

Appendices

		Perpetrator categories regrouped to align with other datasets.
Place where violence occurred	Specify place where assault occurred/where incident occurred (<i>open response</i>).	Coded 1 if in own home; coded 2 if in perpetrator's home; coded 3 if in someone else's home; coded 4 if at a party; coded 5 if at a public event; coded 6 if at school; coded 7 if traveling by car/bus/foot; coded 8 if another location.

Appendix 13: Socio-demographic characteristics of survivors seen at Naivasha

Sub-county Hospitals and Thika Level 5 Hospital

		Naivasha Sub-county Hospital n (%)	Thika Level 5 Hospital n (%)	Total n (%)	P value (χ^2)
Gender	Female	313 (93.4)	193 (92.6)	506 (93.2)	0.772
	Male	22 (6.6)	15 (7.4)	37 (6.8)	
	Total	335 (100)	208 (100)	543 (100)	
Age	Mean age in years (Range)	16.4 (2-67)	17.6 (1-51)	16.8 (1-67)	t-test P=0.1578, (CI 15.990, 17.656)
Age group	18 years and below	233 (75.2)	104 (58.8)	337 (69.2)	<0.001
	Above 18 years	77 (24.8)	73 (41.2)	150 (30.8)	
Marital status	Single	54 (61.4)	69 (77.5)	123 (69.5)	0.008
	Married	21 (23.9)	11 (12.4)	32 (18.1)	
	Divorced	3 (3.4)	4 (4.5)	7 (3.9)	
	Separated	3 (4.4)	5 (5.6)	8 (4.5)	
	Widowed	7 (7.9)	0	7 (3.9)	
	Total	88 (100)	89 (100)	177 (100)	
Orphans & vulnerable children (OVC)	Yes	14 (4.4)	13 (9.1)	27 (5.9)	0.047
	No	304 (95.6)	130 (90.9)	434 (94.1)	
	Total	318 (100)	143 (100)	461 (100)	
Disability	Yes	14 (4.4)	5 (3.1)	19 (3.9)	0.485
	No	308 (95.7)	159 (97.0)	467 (96.1)	
	Total	322 (100)	164 (100)	486 (100)	
Perpetrator known to survivor	Known	257 (77.2)	130 (63.4)	387 (71.9)	0.001
	Unknown	76 (22.8)	75 (36.6)	151 (28.1)	
	Total	333 (100)	205 (100)	538 (100)	
Perpetrator relationship to survivor	Relative	33 (15.6)	16 (16.7)	49 (16.0)	0.017
	Neighbour	66 (31.3)	28 (29.2)	94 (30.6)	
	Friend	38 (18.0)	15 (15.6)	53 (17.3)	
	Boyfriend (not coerced)	40 (19.0)	7 (7.3)	47 (15.3)	
	Partner or ex- partner	4 (1.9)	5 (5.2)	9 (2.9)	
	*Others	30 (14.2)	25 (26.0)	55 (17.9)	
	Total	211 (100)	96 (100)	307 (100)	
Number of perpetrators	1	294 (88.6)	167 (84.3)	461 (86.9)	0.053
	2	28 (8.4)	19 (9.6)	47 (8.9)	
	3	3 (0.9)	9 (4.6)	12 (2.3)	
	4 or more	7 (2.1)	3 (1.5)	10 (1.9)	
	Total	332 (100)	198 (100)	530 (100)	
Type of sexual violence	Vaginal	285 (87.2)	169 (83.3)	454 (85.7)	0.207
	Anal	23 (7.0)	17 (8.4)	40 (7.6)	
	Combined (Vaginal & Anal/ Oral)	5 (1.5)	9 (4.4)	14 (2.6)	
	Non-penetrative	14 (4.3)	8 (3.9)	22 (4.2)	
	Total	327 (100)	203 (100)	530 (100)	
Place of sexual violence	Perpetrator's home	147 (49.3)	36 (33.0)	183 (45.0)	0.001
	By the roadside/bush	59 (19.8)	24 (22.0)	83 (20.4)	
	Survivor's own	55 (18.5)	16 (14.7)	71 (17.4)	

home			
Someone else's			
home	10 (3.4)	9 (8.3)	19 (4.7)
School	1 (0.3)	0	1(0.3)
Market place	1 (0.3)	0	1 (0.3)
+Others	25 (8.4)	24 (22.0)	49 (12.0)
Total	298 (100)	109 (100)	407 (100)

* *Refers to perpetrators where only a few survivors reported each of them and include people known to the survivor through different associations such as local shopkeepers, employers and neighbourhood "motorcycle taxi" riders locally known as Boda bodas.*

+ *Other places where violence occurred include inside vehicles, abandoned buildings*

Appendix 14: Clinical examination, laboratory tests findings and treatment for survivors presenting at the two hospitals

		Naivasha Sub- county Hospital n=335	Thika Level 5 Hospital n=208	Total n=543	p value
Clinical examination findings					
Physical exam	Normal	286 (85.4)	157 (75.5)	443 (81.6)	<0.001
	Abnormal	42 (12.5)	29 (13.9)	71 (13.1)	
	Not documented	7 (2.1)	22 (10.6)	29 (5.3)	
Genital exam	Normal	45 (13.4)	48 (23.1)	93 (17.1)	0.001
	Hymen broken only	173 (51.6)	79 (38.0)	252 (46.4)	
	Hymen broken with other signs	91 (27.2)	49 (23.6)	140 (25.8)	
	Others e.g. anal signs	21 (6.3)	25 (12.0)	46 (8.5)	
	Not documented	5 (1.5)	7 (3.4)	12 (2.2)	
Psychological assessment	Calm/normal	278 (83)	149 (71.6)	427 (78.6)	0.006
	Not calm/ other psychological disturbance	21 (6.3)	19 (9.1)	40 (7.4)	
	Not documented	36 (10.7)	40 (19.2)	76 (14.0)	
Laboratory test results					
HIV	Negative	296 (88.4)	25 (12.0)	321 (59.1)	<0.001
	Positive	2 (0.6)	0	2 (0.4)	
	Known HIV positive patient	2 (0.6)	1 (0.5)	3 (0.6)	
	Not documented	35 (10.6)	182 (87.5)	217 (40.0)	
Urinalysis	Normal	206 (61.5)	20 (9.6)	226 (41.6)	<0.001
	Abnormal	70 (20.9)	18 (8.7)	88 (16.2)	
	Not documented	59 (17.6)	170 (81.7)	229 (42.2)	
Swab microscopy (high vaginal, oral or anal)	Normal	108 (32.2)	29 (13.9)	137 (25.2)	<0.001
	Abnormal	149 (44.5)	38 (18.3)	187 (34.4)	
	Not documented	78 (23.3)	141 (67.8)	219 (40.3)	
Pregnancy test	Positive	30 (12.8)	3 (7.5)	33 (12.0)	0.339
	Negative	204 (87.2)	37 (92.5)	241 (88.0)	
	Total	234 (100)	40 (100)	274 (100)	
VDRL	Positive	2 (0.6)	0	2 (0.4)	<0.001
	Negative	296 (88.4)	10 (4.8)	306 (56.4)	
	Not documented	37 (11.0)	198 (95.2)	235 (43.3)	
Hepatitis B surface antigen	Positive	1 (0.3)	0	1 (0.2)	<0.001
	Negative	268 (80.0)	0	268 (49.4)	
	Not documented	66 (19.7)	208 (100)	274 (50.4)	
1st dose of PEP given	Yes	219 (65.4)	142 (68.3)	361 (66.5)	0.025
	No	106 (31.6)	51 (24.5)	157 (28.9)	
	Not documented	10 (3.0)	15 (7.2)	25 (4.6)	
Reason why PEP was not given	Late presentation	64 (60.4)	28 (54.9)	92 (58.6)	0.299
	Known HIV positive	2 (1.9)	1 (2.0)	3 (1.9)	
	Boyfriend or denies sex	8 (7.6)	1 (2.0)	9 (5.7)	

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	PEP not indicated	11 (10.4)	4 (7.8)	15 (9.6)	
	No reason given	21 (19.8)	17 (33.3)	38 (24.2)	
	Total	106 (100)	51 (100)	157 (100)	
Other STIs prophylaxis	Yes	275 (82.1)	131 (63.0)	406 (74.8)	<0.001
	No	42 (12.5)	37 (17.8)	79 (14.6)	
	Not documented	18 (5.4)	40 (19.2)	58 (10.7)	
ECP given	Yes	134 (55.6)	75 (59.1)	209 (56.8)	0.525
	No	107 (44.4)	52 (40.9)	159 (43.2)	
	Total	241 (100)	127 (100)	368 (100)	

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