



POST RAPE SERVICES IN KENYA

A SITUATION ANALYSIS

POST RAPE SERVICES IN KENYA: A SITUATION ANALYSIS

By:

Nduku Kilonzo

With the support of:

**Dr. Sassy Molyneux
Dr. Miriam Taegtmeier
Dr. Sally Theobald**

December 2003

**Liverpool VCT and care Kenya
P. O. Box 43640-00100,
NAIROBI.
Tel: +254-20-2714590 Fax: +254-20-2723612
Email: nduku@liverpoolvct.org**

**Funded by:
HIV/AIDS knowledge programme,
Liverpool School of Tropical Medicine, UK**

EXECUTIVE SUMMARY

Background: Violence is an important risk factor contributing towards vulnerability to HIV and AIDS (UNAIDS, 1999; Gupta, 2002; Jewkes, 2002a). Scientific evidence suggests safety and efficacy of PEP based on observational studies of occupational exposure and mother-to-child transmission (Wade et.al 1998; Kahn, et.al 2001, Roland, 2002; Rompay et.al 2002). Discussions of opportunities and challenges around post exposure prophylaxis (PEP) to reduce HIV transmission following sexual violence is growing. Gender based sexual violence in Kenya is almost invisible, though reportedly more prevalent than officially acknowledged. Literature on sexual violence in Kenya is limited. Health care workers at primary health centers and Voluntary Counselling and Testing (VCT) sites are reporting increasing numbers of rape clients. There is increasing demand for VCT services and VCT scale-up as a key Kenyan strategy to fight HIV, provide infrastructure, capacity and political support for post rape care services provision.

Objectives: A situation analysis undertaken was aimed at developing a strategy for the provision of comprehensive post rape services in the VCT context. A qualitative study with 3 main objectives was carried out. 1) To review literature and international experience on sexual violence and service provision including the use of post exposure prophylaxis (PEP); 2) To establish perceptions of gender based sexual violence in Kenya; 3) To document and analyse service provision for gender based sexual violence within Kenya.

Methodology: Literature raised no studies on gender-based sexual violence, HIV and PEP from a VCT context. The study focused on 3 districts - Nairobi, Thika, and Malindi selected because of availability of VCT services in each of these and to capture geographical, social and religious diversities. The study was undertaken in 10 VCT sites, 11 hospitals, 6 legal and advocacy support programs. 34 key informants were interviewed and 18 focus group discussions undertaken. Analysis involved comparing and contrasting key themes emerging from different participants (counsellors, community members etc.). The findings from different research sites and research methodologies (focus groups, interviews) were compared and contrasted (triangulation).

Findings: Table 1.1 Summary of study findings

Objective 1: Literature review	• Sexual violence is a key risk factor for HIV infection
	• Limited literature and information on violence in Kenya
	• There are no studies linking HIV, sexual violence and PEP in a VCT context in Africa
	• PEP efficacy in sexual exposures is uncertain
	• Inequity and violence are linked and increase women's vulnerability to HIV
Objective 2: Perceptions of sexual violence in Kenya	• Sexual violence was seen as shameful and survivor blamed
	• People unaware of what to do/where to go in the event of sexual violence
	• Diverse views on rape in relationships were expressed
Objective 3: Facilities and services for post-rape services in Kenya	• Lack of comprehensive services – counselling, clinical care (PEP,STI and pregnancy prophylaxis), forensic examination
	• Poor services in hospitals and police stations
	• No counselling in public institutions except for VCT
	• Poor chain of custody of evidence & lack of legal support for survivors
Additional emerging gaps in Policy	• Weak legislation, poorly enforced
	• No operational policy guidelines or standards for rape management
	• Weak multi-sectoral linkages

Discussions: Greater participation in discussions on rape from male groups in comparison to female groups may suggest less social barriers to public discussions of sexuality for men. Generally, views

presented by male groups seem to edge towards justification and tolerance for rape, in contrast to women groups who felt the need for concerted efforts to address rape. Groups discussions reflect limited concern for rape by communities, often with the blame for rape on the survivor. At institutional levels there is weak legislation and lack of policies, operational mechanisms and standards for addressing sexual violence. The inherent inequities in gender power relations reflected in societal norms and the placement of women viza viz men in sexual relations influences women's vulnerability to violence and HIV. Clearly, effective public advocacy and awareness training on rape requires broader level interventions aimed at women's empowerment. Local interpretations of sexual violence must inform advocacy at the community and national levels for practical and policy responses. Further, advocacy must be taken within the context of the interface between international declarations, national policies, implementation levels and community understandings. The inadequacy of policies, mechanisms and standards provides an opportunity for targeted interventions aimed at addressing sexual violence and strengthening existing links between HIV prevention and care. In conclusion, implementing post-rape services within the VCT framework in Kenya must be grounded on local realities and include: **1)** multi-disciplinary approaches to developing a regulatory framework; **2)** integration of both counselling and clinical management in health care services; **3)** building capacities for services provision and **4)** development of referral systems.

Recommendations of the study

This study recommends the implementation of a strategy for the provision of comprehensive post-rape services in 3 VCT sites located in primary health care institutions as a **pilot intervention study**. The study will identify what is feasible and link policy responses to practical service provision to inform scale-up in Kenya.

Overall policy considerations recommended:

- Development and institutionalisation of operational guidelines and standards for service provision by the Ministry of Health

Operational/logistical procedures for providing comprehensive quality services:

- Put systems in place for client referrals, forensic examination and sample analysis, clinical care, availability of PEP, STI prophylaxis and emergency contraception, counselling services.
- Support supervision structures for counsellors are essential

Training and building capacities to accompany implementation for:

- Counsellors in trauma, HIV testing, on-going support for survivor, family, drug adherence
- Health care workers (Medical, clinical officers, nurse, laboratory staff)

Multi-disciplinary approaches are be used to promote adoption of laws and policies, strengthen district collaboration and partnerships and be used for education and information.

Monitoring and evaluation system be implemented to support data collection and support efficiency and effectiveness of services. Documentation and records be kept at hospital level.

Partnership and collaboration with the Ministry of Health through the Division of Reproductive Health is fundamental to enhancing accessibility and availability of post-rape services in Kenya.

Structure of the situational analysis

This report contains 7 chapters.

Chapter 1: provides *a background* of the situation analysis with a discussion of HIV, gender based sexual violence and VCT in Kenya. Objectives of the study and operational definitions are provided in this chapter.

Chapter 2: *The Methodology* describes the study sites, general study design and the study methods. These are discussed as per objective. A framework for analysis, ethical considerations and limitations of the study methods are provided.

Chapter 3: Discusses *objective 1: to review the experience of post-rape service provision including use of post exposure prophylaxis for survivors of gender based violence in sub-Saharan Africa.* The literature review highlights the methodological approach and gaps in literature reviewed on violence, HIV/AIDS, PEP from a VCT perspective.

Chapter 4 brings out *findings of the objective 2: to establish the perceptions of gender-based violence in Kenya* from the study

Chapter 5 highlights the *findings of the objective 3: to analyse post-rape services and facilities in Kenya.* It includes an analysis of services within the prevention to care and rehabilitation continuum for sexual violence (counselling, clinical care including PEP, legal protection and support).

Chapter 6: *Discusses and interprets the findings* and overall implications of the findings for research and interventions on gender based sexual violence. Consideration is given to the gender power relations and their dynamics on information, social norms and values and responses to sexual violence.

Chapter 7: The *implications of the study finding and conclusions are drawn, and recommendations* provided for the way forward in post-rape services provision in Kenya.

Investigators

Nduku Kilonzo – Researcher - Liverpool VCT & Care Kenya - (study design and development, administration of data collection tools, training of VCT counsellors, Data analysis and report writing)

Dr. Miriam Taegtmeier; Director of Liverpool VCT and Care, Kenya - (Line management, supervisory and consultative role)

Dr. Sassy Molyneux; Research Fellow KEMRI/WELLCOME TRUST - (Training in Qualitative Research Methods for VCT counselors, Support in Data analysis, consultative role)

Dr. Josephine Kibaru; Head of reproductive health/Department of Reproductive Health Care, Ministry of Health (MoH) – (Consultative role)

Dr. Sally Theobald; Gender and Health Group, Liverpool School of Tropical Medicine, (Supervisory and Consultative role)

Collaborating Institutions:

Liverpool VCT and Care, Kenya

Liverpool School of Tropical Medicine, UK

ACKNOWLEDGEMENTS

Acknowledged are the valuable resources, information and support provided by many individuals who cannot all be named here.

Funding: HIV/AIDS Knowledge programme, Liverpool School of Tropical Medicine (LSTM)
Liverpool VCT and Care, Kenya

Logistics, typing transcripts and research assistance: Virginia Kamonji

I specially acknowledge:

Dr. Sassy Molyneux for your consistent support in study design, organizing and running the qualitative research methods course, in data analysis and in report writing.

Dr. Miriam Taegtmeier for your constant moral and technical support and for providing an enabling environment to undertake the study including line supervision during the study process

Dr. Sally Theobald for your consistent support in study design, design of research training, thinking through the study implications and report writing.

I sincerely thank the research team – Agnes Bakari, Allan Muhaari, Cosmas Maingi, Doreen Okoko, Gona Kalama, Hilda Muthee, Lucy Mung'alla, Martin Muchoki, Safina Mwalimu, Stanley Ngara and Virginia Kamonji.

My special thanks to the Malindi team; Gona, Safina and Agnes for your attention to detail, excellent subscriptions and observations that made analysis less taxing and more fun

I wish to acknowledge **ALL** Liverpool VCT and care Kenya staff for moral and logistical support provided in this last year during the study

Nduku Kilonzo

ACRONYMS

ARV	Anti-retroviral
CEDAW	Coalition for the elimination of all forms of Discrimination against women
COVAW	Coalition of Violence against Women
DEVAW	Declaration of the Elimination of Violence Against Women
ECP	Emergency Contraception
FGD	Focus Group Discussion
FIDA	Federation of Women Lawyers (Kenya Chapter)
GBSV	Gender Based Sexual Violence
GoK	Government of Kenya
HCWs	Health Care Workers
HIV/AIDS	Human Immune deficiency Virus/Acquired immunodeficiency Syndrome
HVS	High Vaginal Swab
KEMRI	Kenya Medical Research Institute
LVCT	Liverpool VCT and Care Kenya
MoH	Ministry of Health
NACC	National AIDS Control Council
NASCOP	National AIDS and STIs Control Programme
NGO	Non-Governmental Organization
OP	Office of the President
OPD	Outpatient Department
PEP	Post Exposure Prophylaxis
PTSD	Post Traumatic Stress Disorder
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	United Nations Aids Programme
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing for HIV
WHO	World Health Organization

TABLE OF CONTENTS

<u>Executive summary</u>	3
<u>Acknowledgements</u>	6
<u>Acronyms</u>	7
<u>Chapter 1</u> <u>Background</u>	11
1.1 <u>An overview of Kenya</u>	11
1.2 <u>Background/rationale</u>	12
1.3 <u>Objectives</u>	12
1.4 <u>Definitions of key terms in the report</u>	12
<u>Chapter 2</u> <u>Methodology</u>	14
2.1 <u>Introduction to the methodology of this study</u>	14
2.2 <u>Study sites</u>	14
2.3 <u>Study design</u>	16
2.3.1 <u>Study approach</u>	16
2.3.2 <u>An overview of the study process</u>	16
2.4 <u>Study methods</u>	17
2.5 <u>Framework for analysis for objectives 2 and 3</u>	20
2.6 <u>Ethical concerns and considerations</u>	20
2.7 <u>Quality assurance for the study process for objectives 2 and 3</u>	21
2.8 <u>Limitations to study methods</u>	21
<u>Chapter 3</u> <u>Literature review</u>	23
3.1 <u>Introduction to the shape of the literature review</u>	23
3.2 <u>Methodological approach</u>	23
3.3 <u>Limitations/gaps in literature reviewed</u>	24
3.4 <u>Gender based violence</u>	25
3.5 <u>Human’s rights perspectives of gender based violence</u>	26
3.6 <u>Determinants of gender based sexual violence</u>	27
3.7 <u>Violence as a risk factor for HIV</u>	29
3.8 <u>The extent and cost of gender based sexual violence</u>	30
3.9 <u>Evaluating HIV transmission following sexual assault</u>	31
3.9.1 <u>PEP following sexual assault</u>	32
3.9.2 <u>Concluding discussion</u>	33
<u>Chapter 4</u> <u>Community perceptions of sexual violence</u>	34
4.1 <u>Summary of findings:</u>	34
4.2 <u>What is rape?? What is the context of its existence in Kenya??:</u>	36
4.3 <u>Rape in relationships:</u>	37
4.4 <u>Reasons for rape – is it justifiable??</u>	42
4.5 <u>What makes sexual violence invisible in Kenya??</u>	44
4.6 <u>What do communities say about sexual violence, HIV: linkages and effects??</u>	46
<u>Chapter 5</u> <u>Post rape facilities and services</u>	48
5.1 <u>Summary of findings</u>	48
5.2 <u>Ideal post-rape care services</u>	51
5.3 <u>Health care service provision: services, systems and processes</u>	52
5.4 <u>Legal protection and the criminal justice system</u>	55

<u>Chapter 6</u>	<u>Discussion of findings</u>	59
6.1	<u>Summary of discussions</u>	59
6.2	<u>Gender, age and geographical diversities: an overview</u>	60
6.3	<u>Gender power relations: Information- access and use</u>	60
6.4	<u>Gender power relations: Social norms and values</u>	62
6.5	<u>Gender power relations: Social, legal and medical response to violence</u>	65
6.6	<u>Multi-disciplinary approaches:</u>	65
6.7	<u>Health care perspectives</u>	66
6.8	<u>Legal perspectives</u>	70
6.9	<u>Conclusion to the discussions</u>	70
<u>Chapter 7</u>	<u>Implications and recommendations for post-rape services in Kenya</u>	72
7.1	<u>Summary of study considerations and recommendations</u>	72
7.2	<u>Examining social norms and gender power relations</u>	72
7.3	<u>Policy, advocacy and networking</u>	72
7.4	<u>Health care services provision</u>	73
7.5	<u>Research:</u>	74
7.2	<u>Specific study recommendations</u>	74
<u>BIBLIOGRAPHY</u>		76

ANNEXES

<u>ANNEX 1: DATA SUBMISSION FORM</u>	80
<u>ANNEX 2: FOCUSSED GROUP DISCUSSION GUIDELINES</u>	81
<u>ANNEX 3: KEY INFORMANTS DISCUSSION GUIDELINES</u>	83

LIST OF FIGURES:

<u>Figure 3.1 Continuum of gender based sexual violence</u>	25
<u>Figure 3.2 HIV/AIDS/Violence: The gender vulnerability</u>	28
<u>Figure 6.1 Conceptualising vulnerability to violence and HIV</u>	71

LIST OF TABLES

<u>Findings:</u> <u>Table 1.1 Summary of study findings</u>	3
<u>Table 2.1 Overview of study methodology</u>	15
<u>Table 2.2 Focus group discussions summary table – objective 2</u>	18
<u>Table 2.3 Summary of interviews undertaken – objective 3:</u>	19
<u>Table 3.1 Data collection from South Africa</u>	24
<u>Table 3.1 Documented prevalence of partner violence</u>	28
<u>Table 3.2 Risk of HIV transmission following exposure</u>	31
<u>Table 4.1 Perceptions of rape and its context in Kenya</u>	34
<u>Table 4.2 Perceptions of rape in relationships – differences in views by gender</u>	34
<u>Table 4.3 Perceptions as to whether rape is justifiable or not</u>	34
<u>Table 4.4 Why sexual violence is invisible in Kenya?</u>	35
<u>Table 4.5 What is said about sexual violence:</u>	35
<u>Table 4.6 The South African experience</u>	35
<u>Table 4.7 FGD extract: divergent views on rape in marriage</u>	39
<u>Table 4.8 FGD extract: sexual desire as justification for rape</u>	43
<u>Table 5.1 Summary on health care services for rape in Kenya</u>	48
<u>Table 5.2 Challenges to post-rape services provision</u>	48
<u>Table 5.3 Legislation and the criminal justice system</u>	48
<u>Table 5.4 Post rape health care services available</u>	49
<u>Table 5.5 The South African experience</u>	51
<u>Table 6.1 Gender power relations: information- access and use</u>	59
<u>Table 6.2 Gender power relations: Social norms and values</u>	59
<u>Table 6.3 Gender power relations: Social medical and legal response</u>	59

CHAPTER 1 BACKGROUND

This background section contains an overview of the HIV/AIDS situation in Kenya, the gender related vulnerability to HIV. The role of the Government so far in dealing with HIV and the place of Liverpool VCT and Care Kenya in the framework of HIV interventions are highlighted. The rationale for this study, objectives and definitions of terms and concepts used in the report are provided.

1.1 An overview of Kenya

The Government of Kenya has acknowledged HIV/AIDS as a development challenge. AIDS has led to: a sharp decline in economic productivity; a rise in TB and sexually transmitted infections (STIs) and high rates of deaths and orphans. Approximately 1.5 million people have died from AIDS in Kenya (MoH, 2001). 2.5 million Kenyans are now living with HIV but few know whether they are infected or show any symptoms, and an estimated 200,000 Kenyans develop AIDS annually (ibid.). Of the 2.5 million, 0.22 are children, 0.9 are men and 1.4 are women. Infection levels for women in the age brackets 15 –19 and 20 – 24 years are 5 and 3 times that of men the same age respectively (GoK/OP 2002).

The gender related vulnerability of HIV infection in Kenya is based on norms and responsibilities that may differ between class, tribe, religion, race and geographic area. There is a disproportionate burden on caregivers in taking care of ill family members. Girls are often removed from school to care for the sick (GoK/OP 2002). Gender influences availability and quality of treatment and access to care and support. Statistics on sexual violence in Kenya vary often depending on the source. There is growing evidence of HIV infection due to gender based violence (ibid) and this is seen to constitute a major violation of the human rights of women that are espoused in international and national instruments that seek to preserve dignity and worth of the human person.

Clearly, addressing sexual violence from various perspectives: human rights protection; health care access and crime prevention is a mandate of the government. Given the high levels of HIV prevalence, there have been efforts to establish policy and practical responses to HIV/AIDS. Policy responses have included the establishment of the National AIDS Control Council (NACC) as the national coordination mechanism for HIV interventions. A national HIV/AIDS policy has been drafted and is ready for presentation to Parliament. A national HIV/AIDS strategic plan forms the basis of HIV interventions. A subsequent plan for mainstreaming gender into the National HIV/AIDS strategic plan has been key in identifying and making visible sexual violence within the national HIV/AIDS framework.

In the national strategic plan, VCT has been recognized as an essential component for prevention of HIV transmission and for providing an entry point to care for those who find they are infected and those affected by HIV/AIDS. The planned rollout of VCT to 250 sites in the next year (2004) is a key strategy for Kenya in fighting HIV. This offers an opportunity in service delivery, infrastructure, capacity and political support to: a) provide access to comprehensive post-rape care (including PEP) and; b) support advocacy for practical and policy responses to violence against women as well as strengthen existing links between HIV prevention and care.

Implementation of VCT is done primarily by non-governmental organizations. Liverpool VCT is Kenya's largest VCT service provider having started integrated services in 1998 and plays a key role in supporting national response to HIV and AIDS in Kenya within the HIV policy framework. LVCT is also *the pioneer* in VCT for HIV, and works in collaboration with existing government facilities and resources whilst remaining consistent with LVCT's mission.

LVCT works at policy level (writing of national VCT guidelines and training material) and also works directly with District Health Management Teams to provide technical support to VCT site establishment (counsellor and lab supervision, test kits and reagent supplies, verification of blood samples) and currently manages 49 and has provided technical support to 70% of 218 VCT sites across Kenya). **Recently LVCT has been mandated by the Ministry of Health to undertake Quality assurance of VCT scale-up in Kenya.** LVCT will be undertaking further scale-up of VCT sites under the VCT roll-out plan - a key strategy for HIV prevention and access to care.

1.2 Background/rationale

This study is a situation analysis of post-rape service provision in Kenya and was aimed at developing a strategy for provision of comprehensive post-rape services in VCT sites in Kenya. This situation analysis exercise responded to the findings of a 2002 Thika-based operational research study on the uptake of post exposure prophylaxis for needle-stick injuries in public health institutions by LVCT. In this study health care workers expressed concern over the high levels of sexual violence reported to them in the course of their daily activities. Further, since the introduction of VCT into the primary health care centres, an increasing number of clients at VCT are reporting rape. Both health care workers and VCT counsellors expressed frustration at the lack of skill and basic services to help clients *1) to psychologically reduce fear and anxiety over infection with HIV from sexual violence, and 2) the inability to actually prevent transmission of HIV to survivors of violence.* These gaps have led to a demand to incorporate gender based sexual violence perspectives into VCT processes, services and procedures. Thus the impetus for this work comes from demands from counsellors and health care workers for specialist skills and services to deal with gender based sexual violence. It has also grown out of demands from National priorities in the area of gender and HIV as clearly reflected by the National Gender Mainstreaming Strategic plan for HIV/AIDS (GoK/OP 2002).

1.3 Objectives

a. Aims

To contribute towards the development of a comprehensive strategy for provision of services for sexual violence in VCT sites in Kenya.

b. Specific objectives:

- i. To review the experience of post-rape service provision including use of post exposure prophylaxis for survivors of gender based sexual violence in Sub-Saharan Africa
- ii. Establish perceptions on gender based sexual violence and related services in Kenya
- iii. Document facilities and services for gender based sexual violence in Kenya

1.4 Definitions of key terms in the report

Gender Based Violence: Acts of violence associated with power inequities (in this case between women and men, girls and boys) that result in or are likely to result in physical, sexual or mental harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in private or public life¹.

Sexual violence: Unwanted acts of physical sexual contact and abuse

CHAPTER 2 METHODOLOGY

2.1 Introduction to the methodology of this study

This chapter is divided into 5 sections. The key areas discussed include:

1. **Study sites.** The rationale for selection and description of study areas is provided.
2. **The Study design:** the rationale for use of qualitative methods, type of methods selected and their applications are discussed. The design highlights key steps undertaken in the study process and an overview of the research methods employed.
3. **Study methods:** Each objective is discussed separately with details of the sampling strategies, techniques and data collection tools.
4. **Data analysis:** A framework for analysis of data and quality assurance mechanisms observed for the study process are outlined.
5. **Study considerations:** Ethical concerns, research biases and limitations experienced while undertaking the methodology are discussed.

An overview of the study methodology is available in table 2.1

2.2 Study sites

Three sites were identified as study areas based on the existence of established VCT sites that have been functional for over a year. The rationale was guided by the need to have functional VCT sites with experienced counsellors, well-established supervision structures and a clear integration with primary health care institutions. The selection further took into consideration the need to reflect geographical, religious and social diversities so that lessons are more likely to be applicable to Kenya as a whole. The three sites selected included Nairobi, Thika and Malindi.

Nairobi city is a province and is the Capital city of Kenya. It is an urban centre with diverse populations and demographic characteristics with a cross-cutting representation of all ethnic groups, socio-economic classes and religions in Kenya. Nairobi has 8 divisions, serves a population of over 2,000,000. It is a large commercial centre both for Kenya and regionally, has good infrastructure (transport, communication) and large market. HIV/AIDS prevalence is 16% in Nairobi (GoK, 2002a)

Thika District is in the Central province of Kenya, covers a total area of 1,906.2KM². It borders Nairobi city making it a peri-urban area serving both rural and urban populations. It has 6 administrative divisions, a population of 701,664 (351,511 males and 350,153 females) and 2 distinct topographies. Thika is an industrial district with good communication network, availability of raw materials and a market. HIV/AIDS prevalence is 34% in Thika, with over 60% bed occupancy in hospitals. Majority of those infected with HIV are females aged 20 – 49 years (GoK, 2002b)

Malindi District is in the Coast province of Kenya, covers an area of 7,605 KM² and is divided into 3 administrative divisions. The ocean coastline has good beaches for tourism and fishing activities that have positive effects on economic growth through employment creation and promotion of socio-economic activities. The District population is approximately 305,143 (154,304 male and 150,839 female) with a high population in Malindi town compared to other areas in the district. The district's HIV/AIDS prevalence rate is 15%-17% and is attributed the existence of prostitution (sex tourism), drug use including alcoholism and traditional practices such as 'wife inheritance'. Gender inequality is experienced in education, health care, economic activities, land and other property ownership (GoK, 2002c)

Table 2.1 Overview of study methodology

Objective	sample units	Sampling strategy	Sample area	Sampling frame & no. of Participants (pax)	Methods/tools
1. Review the experience of post-rape service including PEP for GBSV in Africa	--	International literature – both published and ‘grey’	The world – focus in Africa	The internet Published documents Reports and grey literature	- Internet search engine – ‘google’ - Bibliographic data base on violence against women (VAW) by WHO
	People involved in rape policy and service delivery	Study tour – South Africa	Western Cape- SA	6 key informants 2 workshops 4 rape crisis units/centres	- Consultative meetings, Informal discussions - visits to post-rape services
2. Establish perceptions on GBSV & related services in Kenya	Adult Women	Stratified sampling ³	Nairobi Thika Malindi	3 groups (11 +12 +10) 1 group (11 pax) 1 group (8 pax)	Focused group discussions (FGDs)
	Adult men	Stratified sampling	Nairobi Thika Malindi	1 group (7 pax) 1 group (9 pax) 1 group (9 pax)	FGDs
	Adolescent women	Stratified sampling	Nairobi Thika Malindi	2 groups (7+13pax) 1 group (9 pax) 1 group (8 pax)	FGDs
	Adolescent men	Stratified sampling	Nairobi Thika Malindi	2 groups (11 +12 pax) 1 group (14 pax) 1 group (10 pax)	FGDs
	Commercial sex workers	Purposive ⁴	Thika Malindi	1 group (9 pax) 1 group (8 pax)	FGDs
3. Document the facilities, services for gender based violence	Health care facilities	Stratified	Nairobi Thika Malindi	Hospitals 4 (2 private, 2 public) 2 (1 public, 1 private) 3 (1 public, 2 private)	Key informant discussions, semi-structured interviews
	VCT counsellors	Purposive	Nairobi Thika Malindi	2 counsellors 1 counsellors 2 counsellors	Key informant discussions,
	Police stations	Stratified	Nairobi Thika Malindi	4 police stations 1 police station 1 police station	Key informant discussions,
	NGOs/ organizations involved in GBV initiatives,	Snowballing ⁵	Kenya	Legal services/criminal justice /advocacy: 6 Religious organizations: 5 Health care services: 4	Key informants, informal interviews, Workshop participation,

³ Stratified sampling: selecting informants from subgroups of interest to illustrate characteristics of the subgroup and facilitate comparisons

⁴ Purposive sampling: Selecting specific informants to provide specific information that may not be available from other sources

⁵ Snowballing: Locating one or 2 informants and then ask them to name other likely informants. This facilitates the identification of cases of interest.

2.3 Study design

2.3.1 Study approach

A qualitative research approach was selected for use in this study as qualitative approaches potentially provide a comprehensive understanding of complex social settings and a flexible and interactive process that allows discovery of unexpected and unforeseen issues. Qualitative designs include a commitment to view events, actions, norms and values from the perspective of the people being studied. These features were essential in meeting the principal objectives of the study, particularly in the discussion of sexual violence- a sensitive topic. Non-probability sampling was used for flexibility purposes and to maximize on the scope and range of variation in the subject of study. A range of individual and group interview techniques were included in this study. It was felt that the sensitive nature of the study topic was amenable to 'the one to one' setting of interviews. However, focus group discussions were also selected in order to explore the role group dynamics and peer pressure can play in discussing views and perceptions on GBV. There is also an argument that some groups may find sensitive topics easier to discuss in a group environment, depending on group dynamics and the facilitator's skills (Kitzinger, 1995). Focus group discussions included participants selected to meet the sampling criteria of community representatives disaggregated by gender and age in the selected areas. These elicited a broad range of discussion around open-ended topics. Throughout the fieldwork, flexibility in specific methods, tools and questions was maintained to maximize researcher-researched egalitarianism and the discovery of participants' own perspectives (Wilkinson, 1998; Hudelson, 1994; Reinharz, 1992). Reliability was ensured through use of different methods for data collection and triangulation of data.

2.3.2 An overview of the study process

Key steps undertaken in the study process are outlined below:

Training research assistants: A team of 10 research assistants was recruited from among VCT counsellors in Liverpool VCT and Care and trained for 1 week in qualitative research methods. The main criterion used in VCT counsellor selection was interest in undertaking the study. VCT counsellors were selected for their understanding of, and skill in, handling sensitive issues and situations. Their understanding of the need to practice confidentiality was an asset for the study and the training and subsequent research conformed to World Health Organization (WHO) ethical and safety recommendations for domestic violence research (2001).

The study design was discussed in detail with focus on the information needed to address the objectives, sampling techniques and data collection tools. Processes to enhance the quality, reliability and validity of data collected were critical to the training. During the training consensus was reached on roles and responsibilities of the teams, their place as researchers vis a vis as counsellors in consideration of ethical concerns arising from the study and expectations of the teams and principle researcher. As part of the training take home assignments and readings, individual and group exercises were given. Etiquette of the research teams and protocols for group discussions and interviews were set. At the end of the course each research assistant was provided with a course manual on qualitative research methods, an easy-to-read handbook on qualitative methods (Hudelson, 1994) for reference and a practical field manual as a handbook and guide during their field work. Each research assistant was certified for attendance of the 1-week course. A Qualitative Research methods certificate was presented at the end of data collection to show practice in the use of methods.

Data collection and submission:

The research assistants were divided into 3 teams, each with a team leader. One research assistant remained in the central LIV-VCT office to provide logistical support to the teams and another research assistant officer undertook data entry, administration of the teams and backstopping support. The teams undertook a 4 day mobilization exercise from February 24th – 27th in Nairobi and Thika Districts and from March 3rd to 6th in Malindi. Mobilization included: identification of sample populations; discussions with ‘gatekeepers’⁶ to arrange for interviews and discussion and putting logistics in place to collect data. Data collected was then submitted to the research officer where it was entered into a data submission form (*see annex 1*) for entry and analysis. Daily review meetings were held by teams and included literal transcriptions of data collected. Data entry was done based on the original transcriptions produced by the research teams. Weekly meetings of each team with the principle researcher were held to support the process and address any process or logistical issue arising. The principle researcher kept a logbook for entry of methodological decisions made and changes in the planning framework, on interviews undertaken and the ways in which snowballing was used as a sampling technique.

2.4 Study methods

The study methods used included a review of literature and secondary data; study visits, and the use of a range of qualitative and participatory research methodologies (semi-structured interviews, focus group discussions, in-depth interviews, informal discussions and workshops). Each of the different study objectives required specific study methods, sampling techniques and tools. A planning framework was developed and used as a guiding tool for the study.

Methodology for Specific objective 1: Review the experience of post-rape service provision including post exposure prophylaxis for survivors of gender based sexual violence in Sub-Saharan Africa. The methodology is discussed in Chapter 3, section 3.1

Methodology for Specific Objective 2: Establish perceptions on Gender based sexual violence and related services in Kenya

Sampling strategy: Stratified sampling was used to identify respondents from religious institutions; health care workers and ‘high-risk groups’ – specifically commercial sex workers. Women and men were sampled for focus group discussions through existing recognized social structures; the Department of Social Services, the Ministry of Health; NGO/Service providers. Sampling took into consideration gender and age diversities with FGD’s falling primarily in 4 groups – adult women, adult men, adolescent women and adolescent men. Homogeneous groups are often used in FGDs and were particularly pertinent in the context of this study where information sought was sensitive.

Data collection: Focus group discussions were used. Informed consent was sought from all participants. It was made clear to participants that they were under no obligation to participate and would experience no adverse affects from not participating. Discussions took about an hour and a half and the importance of confidentiality was stressed. Each of the discussants were free to contribute or not contribute to any part of the discussion. A VCT counsellor was available for general counselling after the sessions. There were many questions regarding HIV and VCT services in general from most groups. Researchers promised to go back to 2 of the youth groups (1 in Malindi and 1 in Nairobi) and hold further discussions on rape, HIV and VCT issues. A focus group discussion guideline was used to guide relevant information and capture the discussion (*see annex 2*).

⁶These include people in charge of groups or institutions (formally or informally) and are therefore central to communication with members of these groups/organizations or institutions. For instance, the coordinators of youth

Table 2.2 Focus group discussions summary table – objective 2

Sample units	Sample area	Sample frame (area and number of participants per group)	Date of FGD
Adult women	Nairobi	-11 women living with HIV/AIDS different parts of Nairobi -12 Single mothers from Ziwani - 10 participants from Kawangware	17/3/03 14/3/03 15/3/03
	Thika	- 11 participants - Thika town	28/2/03
	Malindi	- 8 participants - Kakuyni	26/3/03
Adult men	Nairobi	- 7 participants- Kawangware	7/3/03
	Thika	- 9 participants – Thika town	20/3/03
	Malindi	- 9 participants - Bahari	28/3/03
Adolescent women	Nairobi	- 7 participants - Mathare - 13 participants – Eastleigh	5/3/03 6/3/03
	Thika	- 9 participants - Gatundu	4/3/03
	Malindi	- 8 participants- Malindi town and environs	12/3/03
Adolescent men	Nairobi	- 12 participants – Mathare - 11 participants - Riruta	5/3/03 10/3/03
	Thika	- 14 participants – Thika town	7/3/03
	Malindi	- 10 participants – Environs of Malindi town	28/3/03
Commercial sex workers	Thika	-Thika town – interview held at Redcross hall	12/3/03
	Malindi	- Malindi town – interview held at Solwodi hall	19/3/03

Methodology for Specific Objective 3: Document facilities and services for gender-based violence in Malindi, Nairobi and Thika

Sampling strategy: Purposive sampling was used to identify key informants from the sample units: private and public hospitals, police stations, relevant government departments and VCT counsellors. Snow balling was used to identify organizations providing services for gender based sexual violence. A point of redundancy was reached after 34 key informant interviews (when information being collected became repetitive). Snowballing (chain sampling) was stopped at this point without having interviewed the originally planned 40 key informants as no new themes were emerging. Data was collected as summarized in Table 3.2 below

A workshop on *'forensic medical examination, care and treatment of rape survivors in Kenya'* held at Naro Moru between March 21st-23rd 2003 was used as a source of information. The workshop had representatives from the legal, advocacy, health services, counselling, care and rehabilitation civil society organizations, 4 government departments from across the country⁷.

Data collection methods:

- An interview checklist and key informant discussion guides were developed for each of the different groups of service providers (*see annex 3*).
- A semi-structured section was attached to interviews done for hospitals to gather information on service provision (*see annex 4*).
- The research officer and the principle researcher undertook in-depth interviews in formal and non-formal settings. Informal discussions and organizational mapping was undertaken.
- In-depth interviews were done at 2 institutions providing free cost post-rape services including PEP; Kenyatta National Hospital, Nairobi Women's Hospital – Gender Violence Recovery Centre.

⁷ A medico-legal network on gender based violence in Kenya was created from this workshop and has been working

Table 2.3 Summary of interviews undertaken – objective 3:

Sample units	Institutions visited	Person interviewed & gender	Tools used	Dates data collected
Police stations	Police stations: 4 stations in Nairobi 1 in Malindi	Inspectors in all stations; all male	Key informant (KI) discussions	3,5,6 & 10 /3/03 18/3/03
Counselling services	Organizations: 2 in Nairobi	Director (M) Supervisor (F)	KI discussions	4/3/03 5/3/03
	Counsellors – 4 in Nairobi 1 counselor – Thika 2 counselors - Malindi	3 VCT (2F, 1M) 1 Diagnostic (F) VCT (1M) VCT (2 M)	Informal discussions	26/3/03 26/3/03
Health care services/ facilities	Private hospitals 3 in Nairobi 1 in Thika 2 in Malindi	1 Clinical officer (F) 1 Programme officer (F) 1 Administrator (F) 1 Clinical officer (M) 1 Medical Doctor (F)	KI discussions	26/3/03 7/2/03 21/3/03
	Public hospitals 2 in Nairobi 3 in Thika 1 in Malindi	1 Nursing officer (F) 1 Clinical Officer (F) 1 Medical officer (M) 1 Forensic expert (F) 1 Lab technician (M) 2 clinical officer (M) 1 Medical officer (M)	KI discussions Informal discussions	20/3/03 28/2/03 7/2/03 21/3/03 18/3/03 26/3/03
	1 academic institution	1 Research coordinator (F)		6/11/2003
	Advocacy, legal services, Education & awareness	6 organizations & institutions in total	1 NGO prog. officer (M) 1 Magistrate (F) 2 Lawyers (M) 1 NGO Manager (F) 2 NGO Prog. managers (F) 1 HIV/AIDS coordinator (F)	Informal discussions KI discussions
Religious institutions	Muslim Catholic Protestant	2 - Council of Imams (M) 1 Catholic priest (M) 2 Pastors (M)	KI discussions	6/3/03 10/3/03 27/2/02
Medico-legal network on GBV members ⁸	Legislation, policy and advocacy organizations Health care service providers Special needs (children, physically challenged) Forensic experts	7 organizations (23 F & 7 M participants) 5 organizations (7 F & 5 M participants) 5 organizations (3 F & 3 M participants) 2 South African 1 Swaziland	Workshop presentations, proceedings	19 th – 21 st /3/03

⁸ Some of the members of the Medico-legal network were talked to as NGO service providers. In this case the network is mentioned with specific regard to the Naro Moru workshop held on 19th – 21st March 2003, on 'forensic medical

2.5 Framework for analysis for objectives 2 and 3

Analysis was carried out on an ongoing basis. Initial immediate debriefing exercises of all focus group discussions were undertaken and the understanding of key terms and perceptions discussed. The research team met at the end of every day or at the earliest time possible and each team met with the principle researcher every week. Transcription of the discussions and informal interviews were undertaken as soon as it was possible after the interview. A context summary sheet was attached to each data collected and reflected the basics of the group discussion or interview: date, participants, issues emerging, quality of data collection process and this was submitted with all the data. A summary of the study processes highlighting emerging themes as perceived by each research team was written and presented at the end of the data collection process. It also included the teams' issues around logistics of the study and pertinent issues for Liverpool VCT in general.

Content analysis was undertaken by the principal investigator with support from the team leaders. This was done through identifying the key themes emerging from the research (Patton, 1990). Dr. Sassy Molyneux provided external input during analysis. Focus group discussions from each of the districts were analysed first. Key themes were drawn and triangulation of these undertaken through comparing and contrasting data from the different districts and the different groups interviewed (gender and age). Both converging and divergent views were highlighted. Analysis of data from key informants and structured interviews was undertaken. Triangulation of information from key informants through comparing and contrasting the main points emerging from different key informants and, triangulation of the different research methodologies was undertaken.

The main theme emerging from the study is that of gender power relations and their dynamics and influence on information access and use (section 6.3), social norms and values (section 6.4) in Kenya and post-rape service delivery at local and institutional levels (section 6.5). Discussions on gaps, implications and opportunities for implementing a strategy for post-rape services in Kenya are shaped from the analysis with conclusions and recommendations being drawn (Chapter 7).

2.6 Ethical concerns and considerations

Ethical consent was sought for the study through a national ethical review body. A proposal was submitted to the Kenyatta National Hospital Ethical Review Committee on January 9th, 2003. The proposal was referred back with requests to clarify the study rationale and expand the research background and references. A proposal was re-submitted and approved. The proposal included a study overview (background, methods), a work-plan and budget, ethical considerations and concerns; ethical consent forms and data collection tools, a framework of analysis, quality assurance mechanisms in place, process indicators and expected outcomes of the study.

Various strategies were employed through the study process to enhance ethical conduct:

1. Ethical approval was sought and acquired for the study.
2. Informed personal consent of study participants was sought at the beginning of each discussion. Participants and respondents were informed of their right not to answer any of the questions.
3. VCT counsellors with skills and experience in handling sensitive issues and situations were used as research assistants. Where respondents may have related to issues of sexual violence, VCT counsellors were able to use their counselling skills to deal with the issues and have a clear understanding and experience with confidentiality requirements.
4. Confidentiality was ensured through the study process: names of participants were only taken at the end of the training and this was specifically for purposes of accounting for transport reimbursements and records were submitted to the research officer. Data was made accessible to those involved in analysis only.
5. Transport was reimbursed to participants who travelled to attend the discussions
6. A drink (tea or soft drink) was provided to participants at the end of the session

A voucher for free access to VCT services at any of the LVCT supported sites was given at the end of the discussions to each participant. Additional vouchers were also given out to participants who requested them for partners, etc. Participants were not informed in advance of the vouchers or the soft drink.

2.7 Quality assurance for the study process for objectives 2 and 3

Qualitative research designs are associated with potential disadvantages including limited reliability. Interviewer and respondent characteristics including gender, age and ethnicity have been shown to influence the way research data is generated and interpreted. For instance understanding and meaning of terms such as sexual violence may vary within different contexts. Mechanisms to minimize such potential biases included; development of a protocol for introductions and contracting between the researcher and interviewer; training in communication skills; sitting arrangements in interview settings. All of these strategies aimed at minimizing power imbalances between researcher and respondents (Reinharz, 1992)

Quality assurance and trustworthiness of the research process and methods was maintained through:

- Training practising VCT counsellors as research assistants. Counsellors understanding of, and skill in, handling sensitive issues and situations and confidentiality was beneficial for the study.
- Training and subsequent research conformed to World Health Organization (WHO) ethical and safety recommendations for domestic violence research (2001).
- To enhance dependability of the study, immediate debriefing and transcription exercise was undertaken. It was useful in developing consensus on meanings of phrases and words used in discussions between those collecting data. It also served to capture the range of perspectives and understanding and kept research assistants aware of the gaps, bias and errors.
- Each of the study teams met with the principle investigator once a week to discuss logistical as well as information needs.
- The use of different methods in different parts of Kenya to undertake the study enhanced the studies' transferability.
- Triangulation was used widely in the study to reduce uncertainty, cross-check information and increase the range of people's input and range of perspective and biases imposed on the study. It also aimed to reduce the 'hawthorne effect' (researcher bias) in the study.

Triangulation included:

- Comparing results of a range of methods during analysis
- Comparing information collected by the different study areas
- Comparing same information from different sources particularly the key informants
- The use of multiple perspectives in the analysis process.

2.8 Limitations to study methods

1. A review of rape registers was anticipated as part of the study proposal. However, these were found to be unavailable in all health care institutions visited. Rape was found to be registered under the casualty or outpatient departments and was entered as 'assault' hence could not be differentiated from other forms of assault.
2. English was the medium of communication in data collection although in some areas data was collected in Kiswahili or 'Sheng' (a common mixture of Kiswahili, several indigenous Kenyan languages and English). Kiswahili and English are often used interchangeably in the Kenyan context. 'Sheng' is a dynamic language – unofficial and used primarily by younger people and is a mixture of various Kenyan tribes, but is predominantly made of Kiswahili and English. Data collected was transcribed directly in English, Kiswahili or 'Sheng' and analysis was done in English. Direct quotes from the respondents in Chapter 4 reflect this mixture of languages. The

use of different languages can challenge the trustworthiness of the research process particularly with regard to the context and inferred meanings.

3. The use of words such as rape and sodomy and dependence on verbal information for very sensitive topics and may not be expressed in settings that were not natural and may have influenced participant abilities to contribute fully to the discussion.

CHAPTER 3 LITERATURE REVIEW

3.1 Introduction to the shape of the literature review

A methodological approach (section 3.2) to the review of literature is provided and gaps in literature reviewed are discussed (section 3.3). Integral to the literature are discussions on sexual violence as a form of gender based violence (hence the report makes references to gender based sexual violence) (section 3.4). Subsequent discussions are grounded on human rights approaches (section 3.5). Though recognition is given to violence in circumstances relating to: the individual, family, community and the broader national context (macro-level political, economic) (Shrader, 1999; Krug et.al 2002), the review focuses mainly on interpersonal violence. The social context and pervasive nature of gender-based violence in its broader sense is explored (section 3.6). The literature review synthesizes findings from the international literature and attempts to clearly present the intersections between gender based violence and HIV transmission. The violent transmission of HIV and AIDS is examined against a background of gender inequality from a global as well as Kenyan perspective (section 3.7 – 3.8). An evaluation is done of the risk of HIV transmission from sexual violence, the use of post exposure prophylaxis (PEP) and critical considerations in PEP administration for sexual exposures (section 3.9). Recommendations from reviewed studies on future directions and interventions are highlighted and discussed later in this chapter (section 3.9.2).

3.2 Methodological approach

Sampling strategy: This international literature review was based on a review of both published and ‘grey literature’ on sexual violence and the use of post exposure prophylaxis in the context of voluntary counselling and testing for HIV/AIDS. Only materials published in English language were used and the Internet was the primary search method.

Data collection methods: The search engine ‘Google’ was employed and key words used were: SEXUAL VIOLENCE, GENDER BASED VIOLENCE, HIV/AIDS, POST EXPOSURE PROPHYLAXIS, WOMEN, VOLUNTARY COUNSELLING AND TESTING. The search focussed on information from the following perspectives: medico-legal, social, law enforcement and judicial. The main database searched was the World Health Organization (WHO) Bibliographic Database on Violence against Women. The meeting report on *Violence Against Women and HIV/AIDS: Setting the Research Agenda* (WHO, 2000), forms a basis for key discussion areas and is frequently referenced. The Global forum for Health Research provided extremely useful pointers particularly in their review of literature on sexual violence found at www.globalforumhealth.org. Other methods included hard searches; reference lists from secondary data and searches of published works.

A study tour to South Africa was undertaken to synthesize and learn and understand the challenges and dilemmas from different experiences in provision of post-rape care in the context of HIV/AIDS. South Africa has moved forward in policy development and institutionalisation on post-rape care. It was also intended to establish a basis for the development of a south-to-south collaborative framework for information exchange, research, advocacy support and experience sharing. Information was collected in various ways as reflected in table 3.1

Information from Kenya was primarily from unpublished works, organization reports and documents and the media. Information from and about Africa found on the Internet was predominantly from South Africa. Research on post exposure prophylaxis (PEP) was largely from developed countries with the exception of South Africa. A review on the use of PEP for sexual assault by CADRE from South Africa (Kistner, 2003) highlights key considerations for post-rape services provision that are discussed in chapter 6.

Table 3.1 Data collection from South Africa

The study tour included:

- Participation in a workshop on: indication for and use of PEP following sexual assault- held in Cape Town, 29th-30th November 2002
- Participation in a workshop by Rape Crisis on dealing with HIV/AIDS in the context of rape – organizational responses
- Discussions and consultations with people involved in post-rape care at policy formulation and service provision levels. These included: Prof. Lynette Denny (UCT – Groote Schuur Hospital), Dr. Lorna Martin (UCT – Forensic Medicine and Toxicology), Phyllis Baxten (Provincial coordinator - Rape Survival Programme), Sr. Joy (UCT VCT centre), Wanjiru Mukoma (HIV/AIDS researcher – UCT), Kathleen Dey (Rape Crisis).
- Visits were made to various post-rape service provision centres including: Khayelitcha rape crisis centre, Thutuzela rape crisis centre and Heideveld rape crisis centre.

Key issues emerging from this study tour are discussed in chapters 4 & 5 in subsections 4.1 and 5.1 respectively

3.3 Limitations/gaps in literature reviewed

Though there were discussions linking gender and sexuality with HIV/AIDS and sexual violence, limited attention was given to using qualitative research to develop theoretical frameworks for understanding sexual violence. There were no studies found that encompassed all three thematic areas integral to this situational analysis: HIV/AIDS, sexual violence and use of PEP in Africa in a VCT context. Most information available is either on HIV/AIDS and violence or HIV and PEP with 2 exceptions:

- A review of literature – Maman, S. et.al, 2000 the intersections of HIV and Violence: directions for future research and interventions, *Social Science and Medicine* Vol 50:459-78. This review notes the limited availability of data on specific pathways and intersections between violence and increased risk for HIV and how being HIV positive affects risk of violence.
- Tanzanian study – Maman, Mbambo et.al. 2001, HIV and partner violence, Implications for VCT in Tanzania, Population Council. The study draws links between HIV and partner violence showing that women who experience intimate partner violence are 2.68 times more likely to be HIV positive.

There was no research on gender-based sexual violence, HIV, PEP and VCT. Most literature available was based on medical and social perspectives of sexual violence. Discussions on legal and judicial dimensions are mainly found in recommendations for interventions by various studies.

Literature generally focused on support and care of sexual violence survivors with limited information on preventative strategies. A literature review by Randall (1997) noted the need for more information on barriers to prosecution of perpetrators and lack of law enforcement against perpetrators. The review pointed out that epidemiological data on sexual violence is sparse and that therefore there is limited evidence for evaluating interventions on sexual violence. It is also worth noting that understanding and measuring (gender based sexual) violence was seen as difficult as it is an extremely sensitive area that occurs within a social context. Eliciting quality and trustworthy information is very dependent on the context of the interview and good interviewer training (Jewkes, 2002a).

Other methodological challenges experienced in studies have included:

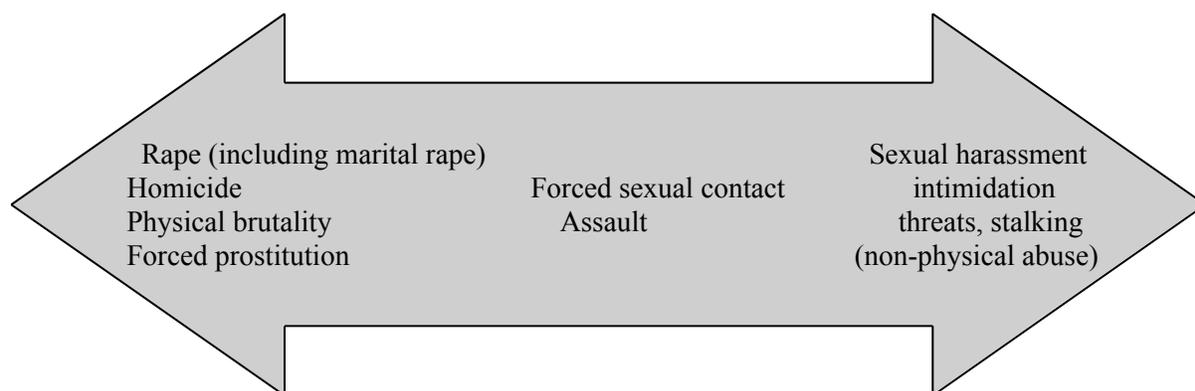
- The lack of a standard method of measurement of violence and timeframes against which to measure violence (in the last 1 year, in your lifetime etc) (Jewkes 2002a)
- The lack of a clear definition of concepts such as rape, gender based violence, HIV risk etc which compounds the difficulty of comparing incidence and prevalence of violence (Garcia-Moreno, 2002).
- Methodological and conceptual differences of researchers in their use of tools and sampling procedures (Sen et.al eds. 2002)
- Ethical dilemmas in different studies of responding to women's experiences of violence (WHO, 2001).

Information on PEP focused primarily on occupational exposure. Data available on non-occupational exposure concentrated on studies from North America particularly the USA and Europe and focused on consensual exposure. Research on HIV transmission through sexual assault remained lacking due to the large ethical and technical difficulties in undertaking controlled trials or population based studies.

3.4 Gender based violence

Three crude distinctions of interpersonal violence have been identified. Crime-related violence, intra-gender (perpetrator and assaulted are the same gender), inter-gender (perpetrator and assaulted are different gender) commonly referred to as gender based violence (GBV). Based on empirical evidence, perpetrators of gender based violence and particularly sexual violence are 'overwhelmingly men' (Randall, 1997). Because over 90% of all violent offences are committed by men against women, gender based violence has alternatively been referred to as Violence against Women (VAW). It includes acts of physical, sexual and psychological violence whether they are in the family or the community. Sexual violence is a form of GBV and has been normatively defined ranging from stalking, sexual harassment, incest to rape by acquaintances or strangers and homicide (Jewkes, 2002a). Conceptualised as a continuum, rape and physical brutality are at the extreme with assault and forced sexual contact in the middle and harassment – threats, intimidation at the opposing end. According to Gordon & Crehan (2000:2), "*at its most fundamental, sexual violence describes the deliberate use of sex as a weapon to demonstrate power over and to inflict pain and humiliation upon, another human being...*". The degree of harm however, is not reflected as directly proportional to the placement of the type of violence in this continuum.

Figure 3.1 Continuum of gender based sexual violence



3.5 Human's rights perspectives of gender based violence

The 1993 World Conference on human rights in Vienna recognized **“the human rights of women are inalienable, integral and indivisible part of universal human rights” and gender-based violence was incompatible with the dignity and worth of the human person.**

As such various international and regional instruments have been put in place to protect women's human rights in cognisance of the pervasive nature of gender-based violence. At International levels these include:

- The **Women's Convention** adopted by the United Nations (UN) General Assembly in 1979 recognizes women's rights to violence free lives.
- The **Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)**, adopted in 1979, in the general recommendation 19 of the CEDAW Committee in 1992 violence against women is referenced as an issue pertaining to discrimination.
- At the regional level, the Protocol to the **African (Banjul) Charter on Human and People's Rights** adopted in 1981, on the Rights of Women in Africa, condemns violence against women and the girl child.
- The **Declaration on the Elimination of Violence against Women (DEVAW)** by the UN General Assembly in December 1993.
- The **Beijing Platform for Action** that calls upon governments to take measures to prevent and eliminate violence against women. At a review of the Beijing PFA in 2000 (Beijing +5), the UN General Assembly, at a special session in 2000, reaffirmed its commitment to eradicate violence against women.

In addition to being a contract between states, human rights treaties also provide a framework of rights that individuals are entitled to claim at national, and in some cases, international level. Various approaches aimed at turning these international commitments made into action at policy level have been developed. They have ranged from the use of women's machineries or special units within governments and organizations to adopting an approach of integrating gender concerns into every aspect of an organizations priorities and procedures referred to as 'gender mainstreaming' (March et.al, 1999). A potential weakness of the mainstreaming approach is in its focus on analysis with policy statements remaining at the national level on paper and may not get to implementation levels. National commitments therefore disappear in what Derbyshire (2001) refers to as 'policy evaporation'. Moser (1993) identifies the lack of technical capabilities and simplified tools for planners to use in gender mainstreaming efforts. She presents a shift in planning from a welfare approach to one that embraces women's empowerment as a goal. Within this context, Moser distinguishes between gender practical needs and strategic interests (section 1.4) and highlights the importance of addressing these needs and interests in interventions.

It is clearly the responsibility of states that have these laws ratified to ensure their enactment and enforcement. While these instruments have been advanced and ratified by many countries, gender based violence is still pervasive as evidenced in literature (Heise et.al, 1999; Gupta, 2000). Possibly because of their historical subordination, many laws, policies and practices constrain women's lives and hinder their full participation in public life as in the case of Kenya (Kibwana, 2000; FIDA, 2002). Thus women often face abuses not only at the hands of state officials but in environments in which they may expect safety and at the hands of individuals known to them as employers, partners, husbands, family members or neighbours (Randall, 1997). Human rights laws are not silent of these abuses and clearly point to a positive responsibility on the part of the state. But this responsibility has too often been overlooked and too often misunderstood or simply not enforced. Yet that responsibility forms an essential part of the protection that the human rights system is supposed to avail to women.

One of the approaches for holding the state responsible for abuses within its responsibility is the standard of due diligence, under which states must prevent, investigate and punish acts, which impair any of the rights recognized under international human rights law. Further, attempts need to be made to restore rights and compensate violations. The 'Optional Protocol' to the UN Women's Convention offers a direct means for women to seek redress at International levels for violations of their rights under the Women's Convention (Amnesty International, 2002). This increasing application of a human rights discourse provides a moral momentum for response towards sexual violence.

In cognisance of its consequences and impact on health and health services, the World Health Assembly declared violence a major public issue in 1996. Gender based sexual violence is recognized explicitly. Part proposals for the way forward are based on national action plans that include review and reform of legislation and policy, building data collection and research capacity, strengthening services for survivors and developing and assessing prevention responses (Krug et.al 2002). Even with international conventions and accords, gender based violence has been identified as primarily a private concern.

3.6 Determinants of gender based sexual violence

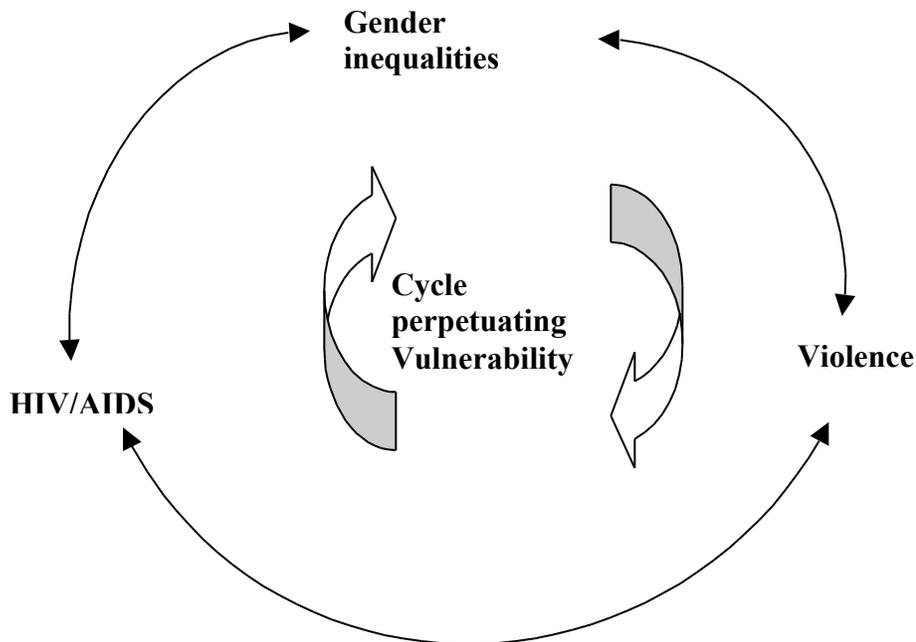
Social and demographic characteristics that have been studied as risk factors for violence include: age, age at marriage, number of children and living in large or crowded homes. However, different studies revealed varying and sometimes conflicting results (Maman, 2000; Jewkes, 2002a;) and such differences might be attributed as much to different study designs and cultural variations as to the characteristics expected. Maman's (2000) collation of studies on HIV and violence highlight a relationship between forced sex and HIV in the context of situations of poverty. Suggestions advancing poverty as a risk factor increasing violence against women identify its effects on conflicts especially those brought about by lack of finances, stress and frustration and gender roles in a situation of inadequacy (Jewkes, 2002a, Sen et. al, 2002). The placement of many women in a poverty cycle is characterized by poor educational status, job opportunities, housing and limited decision-making power. For instance, women's high education levels are often concomitant to social empowerment, access to information and resources and responsibility in their public domain and have been associated with low levels of violence.

Jewkes (2002a), however shows a non-linear relationship between education, economic and social empowerment of women and violence in South Africa where mainly women with the highest and lowest levels of education seem to have protection against violence. She argues that economic inequality within a context of poverty is more important (especially if women seem to be in the better economic position) than the absolute level of income of a woman or man in the relationship. In Kenya, 53% of the population lives below the poverty line, with higher prevalence and intensity of poverty among female-headed households (79.5%) in comparison to male-headed households (58.8%) (GoK, 2000). Farmer et.al., (1996) in their analysis of women, poverty and HIV/AIDS see the interface between individual, communal and institutional related factors that influence poverty, gender power relations and subsequently HIV as structurally determined and perpetuated. Examining gender power relations therefore is critical to understanding pathways in which violence and victimization increases women's risk and vulnerability for HIV.

The normative use of violence has been conceptualised as women bearing the brunt of some males' need for reconfirmation of male power (Jewkes, 2002a), while others hold that violence may not just be about male superiority and dominance, but about male vulnerability and the identity crisis of unachieved masculinity which is particularly pronounced in the context of poverty (FIDA, 2002; Gelles, 1998). Clearly emerging are links between theories underscoring the feminisation of poverty and inequities in the context of changing experiences and expectations of gender identities, for

instance, women are increasingly becoming breadwinners in households. The arising interactions and resultant power relations influence women's vulnerability to violence and HIV/AIDS. These are illustrated in figure 2.1 HIV/AIDS and Violence: The gender vulnerability cycle.

Figure 3.2 HIV/AIDS/Violence: The gender vulnerability



Fear of retribution, economic dependence on perpetrators, the shame of divorce and separation, sense of failing, stigma and social seclusion are barriers to women reporting violence or leaving abusive relationships (Campbell & Nedd, 1999; Heise et.al, 1999; FIDA, 2002). Over 50% of women in a Kenyan survey who knew their HIV status, had not disclosed their status to their partners for fear of violence and abandonment (AI, 2002). Jewkes (2002b) sees much sexual violence taking place in marriages and families as being supported by a cultural approval of rape as a strategy for control and discipline of women. Studies around the world testify to this and have documented the high prevalence of sexual violence against women worldwide both from partners and others (see figure 2.1).

Table 3.1 Documented prevalence of partner violence

Place	
USA	10 women are killed by their partners with 74% of these deaths occurring after women leave the relationship (Gordon & Crehan 2000)
Zimbabwe	59% homicides of women committed by intimate partners (Gordon & Crehan 2000)
Vietnam	70% of 22,000 divorces in 1991 were sought because of violence (Gordon&Crehan, 2000);
South Africa	44% of 1394 men admit to abusing their female partners (Ceaser, 2001)

3.7 Violence as a risk factor for HIV

The true extent of sexual violence is unknown, though available data suggests that one in three to five women may experience sexual violence in their lifetime (Gordon & Crehan, 2000; Jensen & Otoo-Oyortey, 1999; WHO, 2002). For many young women, sexual violence begins in childhood and adolescence; with almost a third of adolescent girls reporting forced sexual initiation (Heise et.al., 1999). Current data also points towards the need to recognize and accept that forced sex and rape is less frequent between strangers and more common among family members, partner and acquaintances (Garcia-Moreno, 1999; Moore, 1999). Of clear concern is the emerging evidence world-wide that violence is an important risk factor contributing towards vulnerability, particularly of women to HIV and AIDS (UNAIDS, 1999; Jewkes, 2002a; Gupta, 2002).

Literature discussing gender based and particularly, sexual violence in Kenya is limited. However, reports by Kenyan police, the media and various non-governmental organizations show increasing prevalence. There is *“growing evidence that a large share of new cases of HIV infection is due to gender-based violence in homes, schools, the workplace and other social spheres. Not all young people have sex because they want to. In a nationwide study of women 12 – 24 years old, 25% said they lost their virginity because they had been forced. A recent Nairobi study indicated that 4% of HIV infections in the adolescent 13 – 19 year age group were a consequence of rape”* (GoK/OP, 2002: 2). 4% of HIV infections in adolescents in Kenya (13-19years) are a consequence of rape (ibid). 24% women in Kenya (17 – 77 years) have been raped at least once as adults (Johnston, 2002). Statistics on sexual abuse vary, reporting 60 to 600 rapes daily (Amnesty International & Coalition of Violence Against Violence respectively). It is estimated that over 70% of rape goes unreported to the Police (Opala, 2002).

A domestic violence survey in Kenya by Federation of Kenya Women Lawyers (FIDA), (2002) showed that 51% of the respondents (women visiting ante-natal clinics in 4 study sites in Nairobi) reported having been victims of violence at some point in their lives, 65% from their husbands and 22% from strangers. In a study of 324 HIV positive women in Kenya, 19% experienced violence from their partner (Watts, 2001). At a ‘consensus building’ meeting on mainstreaming gender in the Kenya national HIV/AIDS strategic plan discussions clearly pointed to growing evidence and concern of HIV infection due to gender based violence in homes, schools, workplaces and other social spheres in Kenya⁹.

While more research questions remain as to the precise interactions and pathways between different forms of gender violence and HIV, there is evidence that there are inter-linkages. HIV positive women are 2.68 times more likely to experience violence (Maman, et.al 2001). In North Carolina, USA, women who reported violence were more likely to have STDs (Moore, 1999). Abused women are also more likely than other women to engage in behaviour that increases their risk of exposure. Krishnan (2000) reveals the centrality of gender inequalities in shaping women’s vulnerability to STIs (and HIV/AIDS) from an ethnographic cross-sectional survey conducted in India. The study investigated aspects of women’s vulnerability to STIs in the context of marriage and reflected in figure 2.2. Violence, beating, sexual coercion and verbal and psychological abuse were closely tied to women’s sense of vulnerability.

While gender is a culture-specific construct, Rao Gupta (2000) sees consistency (even if in varying degrees) across cultures in the differences between women’s and men’s roles, access to and control over productive resources and decision-making authority. Research shows a strong circular correlation between gender and HIV and AIDS, where gender inequality drives HIV/AIDS, which in

⁹ The meeting was organized by the Gender and HIV/AIDS technical sub-committee of the National AIDS Control Council and held at the Serena Hotel Nairobi, on Friday 8th November 2002. An outcome of this meeting has been the

turn entrenches gender inequality (UNAIDS, 1999; Tallis, 2002). According to Tallis (2002), gender inequality is evident in all stages of the prevention-care continuum, affecting possibilities of prevention, access to information and resources and the chances of survival for women and men differently. Norms of femininity and masculinity influence and shape sexuality and are often determinants of risk and vulnerability to HIV/AIDS.

Concepts of masculinity encourage multiple sexual partners for men and subsequent engagement in risky sexual practices. Martin & Kilgallen et. al, (1999) stated that Indian men engaged in extra-marital sex were 6.2 times more likely than men not engaged in extra –marital sex to abuse their wife, hence increasing their vulnerability to HIV and AIDS. Randal (1997) in discussing links between sexual violence, HIV/AIDS and reproductive health highlights the vulnerability of women sex workers to sexual abuse and rape from clients, prostitute cartels and the police based on Jenkins (1998) study. Femininity on the other hand is often expressed in dependency, passiveness, shyness and unquestioning loyalty (especially to husbands) and can act as a social barrier to women’s access to information on sex, HIV and AIDS. Women’s reduced bargaining and negotiation power in sexual relations reduces their choices of acceptable partner behaviour and places them at increased risk of violence and HIV infection (Garcia-Moreno, 2002; Gordon & Crehan, 2000; Gupta et.al, 2002; WHO, 2002). Gender relations exercised in patriarchy often form the basis of norms regarding property ownership, resource distribution and control and expected behaviour. Physical violence and repeated rape by brothers of their dead brother’s spouse has been documented in Kenya. Women in these settings lose their (husband’s) property and are often themselves “inherited”(Amnesty International, 2002; Opala, 2002). ■

Physical/sexual abuse in childhood and adolescence has been associated with high sexual risk-taking behaviour including a higher likelihood to engage in unprotected sex, multiple partners and the exchange of money and drugs. Population reports (1999) put sexual assault victims of 15 years or younger as 66% of all sexual assault victims of all age groups across the world based on information from Chile, Peru, Mexico, Malaysia and Papua New Guinea (Heise et.al, 1999). In South Africa, 32% of 191 teenage mothers, reported that their first intercourse had been forced, 11% had been raped and 78% would be beaten if they refused sex (WHO, 1999). ‘In-depth’¹⁰ focus group discussions with adolescents in Kenya reveal that coercion of female partners is common, where boys admit seducing girls first and if this fails, they use force (Mensch, 1996). According to Amnesty International (2000:9) in Kenya, *“there is a reported pattern of abuse by men who target minors for sex in the belief that they are less likely to be infected with the HIV/AIDS virus. Men infected with HIV/AIDS have reportedly raped young girls under the illusion that they will be ‘cleansed’ by having sex with a virgin”*. This increases their vulnerability to HIV and AIDS (Heise et.al, 1999; Maman, 2000;).

3.8 The extent and cost of gender based sexual violence

The cost of violence is reflected at individual, community and institutional levels. At the individual level, the cost of violence is reflected in the destruction of women’s quality of life, diminishing productivity and eroded self-esteem and worth; all of which impacts negatively on families. Emotional consequences expressed in the ‘rape trauma syndrome’ are often longer lasting and more difficult to diagnose and deal with. Further, women with a history of physical or sexual abuse are at increased risk of unintended pregnancy, sexually transmitted infections and adverse pregnancy outcomes (Heise et.al, 1999; UNAIDS, 1999; Garcia-Moreno, 2002). Resultant sexually transmitted infections (STIs) common during rape and unintended pregnancy increase susceptibility to HIV infection and adverse pregnancy outcomes. This has consequences not only for the individual but

¹⁰ Focus group discussions are normally ‘in-depth’. However, the term has been used here as was used by Mensch

the community in health care and general welfare costs. According to a US observational study, rape resulted in pregnancy in about 5% of women occurring mainly among adolescents. The physical consequences of violence are easier to enumerate than psychological, emotional consequences that are often longer lasting and may be expressed in ‘rape trauma syndrome’.

Macro-economic research has identified direct costs of violence to the economy in medical and health systems (through increased morbidity and mortality), law enforcement and legal and social services (Burton et.al., 2000; WHO, 2002). Gender based sexual violence is increasingly gaining visibility as a major public health concern as it increases women’s long term risk to various health problems (pain, disability, drug and alcohol abuse and depression). In fact, Gordon & Crehan (2000:3) note “*violence as significant a cause of death and incapacity among women of reproductive age as cancer and a greater cause of ill-health and death than traffic accidents and malaria combined*”. Unwanted pregnancies result in unsafe abortions or injuries and complications from lack of follow-up care.

3.9 Evaluating HIV transmission following sexual assault

Within a background of increasing HIV prevalence especially in Africa, sexual violence and the risk of HIV transmission adds a layer of fear and anxiety (Randall, 1997). Post rape medical evaluation and treatment increasingly includes HIV testing and provision of prophylaxis particularly in developed countries. While the use of post exposure prophylaxis (PEP) reduces risk of HIV transmission, there are questions regarding:

- The baseline risk of sero-conversion after sexually violent exposures
- The lack of efficacy data on PEP use for sexual violence
- Clients dealing with HIV status issues and PEP use at a traumatic time;
- Impact of PEP on other post rape services

(Kim, 2000; Smith, 2001; WHO 2001; Rolland, 2002)

Recommendations for PEP use for accidental exposure by health care workers are based on studies that demonstrated 79%-81% reduction in the likelihood of HIV infection (CDC, 1998; Bamberger 1999; Rolland, 2002;). The probability of infection from sexual exposure varies and literature suggests that it is lower than that of infection through other routes of exposure (Katz & Gerberding, 1997; Bamberger et.al 1999). The hierarchy of sexual risk runs from receptive anal intercourse to receptive oral ejaculate.

Table 3.2 Risk of HIV transmission following exposure

Exposure	Likelihood of transmission (per 10,000 exposures)
Needle-sharing injection	67
Percutaneous (HCWs)	30
Receptive anal intercourse	10 - 30
Receptive vaginal intercourse	8 – 20
Insertive anal sex	3
Insertive vaginal sex	3 to 9
Receptive oral ejaculate	No documented cases

Bamberger et.al., 1999, PEP for HIV infection following sexual assault, Am J Med, Vol 106,324 (with adaptations)

The likelihood of transmission of HIV following sexual assault depends on three major factors:

- The probability that the perpetrator is infected with HIV (HIV prevalence in the area);
- The clinical status of assailant infection (stage of infection) and
- The type of exposure (body fluids and routes of exposure, integrity of mucosa, number of discrete contacts).

(Bamberger, 1999; Rolland, 2002; Smith, 2001; WHO 2001).

Risk of transmission increases with sexual assault compared to consensual sex because of high levels of accompanying violence, increased risk of micro-trauma to vagina, genital injury which is common, anal rape, multiple penetrations, multiple perpetrators and ejaculation during rape (Rolland, 2002). In addition resultant sexually transmitted infections common during rape increase susceptibility to HIV infection (Bamberger 1999; Smith, 2000).

3.9.1 PEP following sexual assault

The use of post exposure prophylaxis has mainly been reserved for occupational exposure due to limited data on efficacy of this therapy for non-occupational HIV exposure (Katz & Gerberding, 1997; CDC, 1998; Laporte et.al 2002). Data from occupational PEP, mother to child transmission studies, animal models and observational studies support the biological plausibility of using PEP for sexual assault (Wade et.al, 1998; Kahn, et.al, 2001; Gray et.al, 2002; Rolland, 2002; Rompay et.al, 2002). There is no efficacy data directly supporting PEP use in sexual (mucosal) exposures. HIV infection depends on viral dose and transmission route (blood contact or mucous membrane) making uncertain the validity of generalizing results of non-mucosal exposures to mucosal exposures, though risk for infection is similar (Royce, 1997; Kahn et.al, 2001). There have been no controlled or population-based studies to evaluate PEP efficacy for sexual violence. There are clear ethical concerns regarding setting up a control group and withholding PEP given the convergence of supportive data.

Technical considerations include the population size (thousands of study subjects) needed to set up a randomised trial (Bamberger, 1999; Rolland, 2002;). Smith (2001) argues that despite the moral pressure to provide PEP for sexual violence, the potential benefits are currently unproven. Where PEP has been prescribed for sexual assault, reports indicate that acceptance of PEP medication, completion of regimens and follow up rates, remain poor (Smith, 2001; Laporte et.al 2002; Rolland, 2002). Though there may be benefits for a small number of people, potential risks and costs for PEP as population strategy may be much higher. Concerns raised include:

- The potential development of resistance to anti-retrovirals as observed in a San-Fransisco feasibility study on non-occupational PEP provision to discordant couples who have consensual sex, where resistance rates for various anti-retrovirals range from 20–60% (Kahn et al, 2001);
- The side effects of drugs and toxicity that reduce adherence (Merchant & Keshavarz, 2001; Rolland, 2001). Most side effects have been reversible, though the true rate of adverse effects is unknown
- The effect of PEP use on primary prevention campaigns of safer sex. Data from France shows increase in demand for PEP after consensual sex (Laporte et.al 2002). This contradicts results showing no behaviour change in population in San-Francisco (Katz & Gerberding 1997), raising concerns to the real effects.
- Services necessary to support good adherence to PEP become fundamental to service provision (Smith, 2001).

3.9.2 Concluding discussion

What remains clear is that *“HIV PEP should be provided in the context of a comprehensive treatment and counselling programmes that recognizes the physical and psychosocial trauma experienced by victims of sexual assault”* (Bamberger, 1999:323). Effective counselling is seen as essential component of post sexual violence treatment. Maman (2000) notes that VCT offers a unique opportunity to address the problem of violence among women living with or at risk for HIV infection. Many studies of VCT or risk reduction counselling have demonstrated reductions in risk taking behaviour or/and have reduced STD or HIV rates. As observed by Rolland et.al (2001:1611), *“establishing comprehensive post-exposure prevention programmes that incorporate risk reduction counselling with medication may facilitate integration of clinical and prevention services that traditionally have been separated”*. There are views that developing an agenda for action research can appropriately strengthen the links between research, interventions and monitoring and evaluation of interventions (WHO, 2001). This gives credence to the implementation of a strategy for the provision of comprehensive post-rape services within a VCT context as an operational study.

From the literature, most information and statistics available from different parts of the world are based on survey studies. While these provide information on which advocacy for policy can be hinged, use of surveys to study highly sensitive areas presents various methodological challenges (section 3.3). Key among them is the lack of contextual in-depth information and local understandings. This means that social contexts and existing interpretations are not captured within the study process, presenting challenges for developing informed responses. The qualitative methods (focus group discussions and in-depth interviews) used to collect data presented in the following chapters (4 & 5) were therefore aimed at capturing existing contexts and developing a comprehensive understanding of complex social settings within which sexual violence occurs and is responded to in Kenya.

CHAPTER 4 COMMUNITY PERCEPTIONS OF SEXUAL VIOLENCE

Findings in this chapter refer to objective 2: to establish perceptions of gender-based violence from communities. Focus group discussions (FGDs) were used for data collection. All quotes in this chapter are from FGDs, unless stated otherwise. The chapter begins with textboxes providing a simplified overview of the findings based on the following emerging themes: perceptions of rape and its context in Kenya (section 4.2); perceptions of rape in relationships (section 4.3); perceptions of whether rape is justifiable or not (section 4.4); why sexual violence is invisible in Kenya (section 4.5) and discussions on the effects and what to do about sexual violence (section 4.6). A textbox on the South African experience relevant to this chapter is provided in the summary of findings.

4.1 Summary of findings:

Table 4.1 Perceptions of rape and its context in Kenya

<ul style="list-style-type: none">• Rape is perceived as forced sex that happens to women by strangers in a dark and dangerous place – ‘stranger-in-the-dark-alley’• In each group participants noted alleged rape incidents by known assailants• Rape is generally viewed as penetration of the vagina by a penis• Participants in general and females more specifically found it difficult to discuss sex, sexual organs and sexuality• Male groups expressed more tolerance and justification for rape than female groups• There was confusion between sodomy and homosexuality for participants from all groups

Table 4.2 Perceptions of rape in relationships – differences in views by gender

<ul style="list-style-type: none">• There were divergent views on rape in relationships. More male participants felt there is no rape in marriage, than female participants.• Where rape in marriage was noted as existing, there were no clear distinctions as to what it constitutes• More male participants expressed the view that men should be able to have sex when they wish in their marital relations which is not always seen as the case for women• Women were seen by both women and men to be responsible for ‘unwanted sex’ in relationships (particularly non-marital relations) since they consent to the relationships in the first place• There is absolutely no justification for rape – was a sentiment reflected primarily by female and by male participants as well.

Table 4.3 Perceptions as to whether rape is justifiable or not

<ul style="list-style-type: none">• ‘Women’s mode of dress is responsible for their being raped’, ‘If women dress provocatively then they cannot blame men for being raped’ – were reasons provided by both female and male groups for rape• The media, drugs and alcoholism were seen to have influenced increase in rape by both male and female adolescent groups• ‘African girls say no to sex when they mean yes’ hence they will sometimes ‘want’ to be forced’ was a sentiment reflected primarily by male and by some female participants

Table 4.4 Why sexual violence is invisible in Kenya?

Women generally do not report sexual violence when it occurs. Reasons given for this include

- Stigma by the family and people known to the person raped
- Blame on the survivor for putting themselves in the situation in which they were raped
- Humiliating treatment by the police, in hospitals
- Values of virginity attached to girls make them unable to report
- Sodomy is considered worse than rape

Table 4.5 What is said about sexual violence:

- Many people do not think/consider the long-term effects of rape
- There is limited connection between long-term and short-term effects of rape
- There is limited awareness of what to do, where to go, what to expect in the event of rape
- There is limited connection between HIV and rape

Table 4.6 The South African experience

Key issues emerging from the study tour to South Africa with regard to perceptions of sexual violence:

Advocacy has recently brought rape to the fore as one of South Africa's biggest social challenges and the Government has taken action towards addressing rape in policy and financial commitments. Visibility of rape is mainly in the Western Cape where advocacy has been concerted and infrastructure development undertaken. According to discussions with various participants from different parts of the country in a workshop: 'indications for PEP for use after sexual assault', in other parts of SA and especially rural SA, rape is still considered:

- 1) a family issue, therefore not to be discussed;
- 2) taboo to discuss especially in public;
- 3) something shameful and therefore should be left alone.

It was noted to be more common among the low-income groups. However, there are questions regarding reporting patterns among the higher income groups and the fact that they can afford to seek private medical care and legal services that is often not captured in data collection. Rape was seen to have most severe psychological effects on women living in cultural/religious settings where virginity is highly valued e.g. Muslim. Myths surrounding women's sexuality who have been raped such as 'they change their sexual orientation and become lesbians' - which is considered unacceptable - makes rape in these communities harder to deal with.

HIV/AIDS as still very stigmatised and not talked about partly because it touches on (a closed subject – sex) and partly because it is '*the dreaded disease*' (this was the reference made to AIDS by a female workshop participant). Information levels on HIV and AIDS are low with myths still prevalent (discussion with one of the key informants). Health Care Workers (HCWs) and practitioners were seen not talk about HIV.

Source: compiled from key informant interviews, workshop discussions and rape crisis site visits

4.2 What is rape?? What is the context of its existence in Kenya??:

In each of the groups, discussions on understanding of rape reflected differences within the groups. There was general consensus in all groups that rape refers to being forced to have sex. This was seen in expressions such as *'being forced'*, *'without consent'*, *'unwilling'* that were used by various groups in the different places. There were variations however, as to what constitutes force. While 2 female adult groups in Malindi and Nairobi noted that rape is mainly done by people known to the raped person, what was clearly agreed on by all groups was *'the-stranger-in-the-dark-alley'* perception of rape - where a person is attacked by their assailant as they go about their normal business and are hurt in the process, such as when walking home from work or during a violent robbery.

Rape for most groups referred to penetration of a vagina by a penis. Insertion of things into the vagina by use of force was cited as rape in 2 adult female group discussions (1 in Nairobi, 1 in Thika). Explicit descriptions of sex and sexual organs were avoided and these were often referred to by other means from which inferences were made. For instance;

"kufanya hivyo" [to do like that – in reference to sex] (male adult, Malindi),

"kutumia hiyo kitu" [to use that thing – in reference to a penis] (male adolescent, Thika);

"kutumia [to use] the right channel" [in reference to a vagina] (female adult, Thika).

Varying sexual orientations: In most groups discussions on rape were interlinked with discussions on the different forms of sexual practices including homosexuality and lesbianism. There was lack of clarity in distinctions between sodomy and homosexuality and lesbianism (with the exception of heterosexuality). Sodomy was described often as consensual sex between two men, though in all groups there were divergent views. For instance in one focus group discussion sodomy was described as

"love between two men" (adult male, Thika)

while another participant questioned

"so, if I am gay, and have a gay partner, is that sodomy?" (adult male, Thika)

Focus group discussions particularly from Thika felt that homosexuality and lesbianism did not exist much in their communities. 2 female and 1 male adolescents from Thika had never heard of lesbianism while a female participant from Thika had not heard about homosexuality.

Homosexuality was seen as a diversion away from the norm and described in various ways;

"un-human ways of having sex" (male adult, Thika);

'foreign' (adolescent, male Malindi).

Groups in Nairobi noted that homosexuality was happening though most expressed disapproval, noting that this was against God and religion, and some members felt that people had a right to choose their sexuality,

"si mtu akitaka kuwa gay anaweza kuwa pia" [if someone wants to be gay, they can just be (adolescent female, Nairobi)].

Homosexuality was closely associated with and discussed in the context of religion in most groups where it was felt that God or Allah had made females and males for purposes of procreation and that homosexuality was defying God or Allah. It was often seen or described as evil. Homosexuality was often associated with *'white people'*. In Malindi, many group discussions noted the presence of homosexuality and laid the blame on;

'foreigners' [in reference to tourists and a large population of immigrant Europeans].

"who have brought these evil actions to us" (adult male, Malindi).

Religious leaders interviewed were reluctant to discuss homosexuality and generally denied its existence;

“hili ni jambo ambalo halifanyiki baina ya Waislamu” [this is something that does not happen among Muslims (Islam religious leader, KI, in-depth interview)],

“Christians here do not engage in this kind of evil” (protestant religious leader, KI, in-depth interview).

In one interview, a key informant (religious leader) ‘corrected’ the interviewer and asked him to refer to sodomy or rape as ‘child abuse’ as there was no rape in his community.

In all groups, there was also confusion between rape and sodomy. It was unclear whether rape refers to penetration in the vagina only, whether sodomy refers to penetration of the anus for men only or women as well. Male rape by men was the most agreed on reference for sodomy through the discussions.

4.3 Rape in relationships:

Marital rape: The question of rape in marriage elicited diverse opinions in all group discussions. The general consensus in 3 groups (2 male, 1 female) in Thika, all groups in Malindi and 2 male groups in Nairobi was that, rape cannot be said to occur in marriage. Some participants were categorical about the non-existence of rape in marriage,

“hiyo kitu hamna” [that thing is non-existent (adult male, Malindi)].

This was based on arguments of the implied automatic consent for sex in marriage;

“kama umemarry unagree na all that comes with marriage na hata kumshugulika bwana wakati wote” [if you marry, you agree with all that comes with marriage including catering for your husband at all times (female adult, Nairobi)].

The lack of a legal provision for rape in marriage in Kenya was seen as an indicator that there was no rape in marriage

“Hata ukiangalia katika zile law zetu, hakuna kitu kama hiyo baina ya watu wameowana” [Even if you look at our laws, there is nothing like that between people who are married (adult male, Thika).

The marriage institution based on traditional African, Muslim and Christian beliefs that do not acknowledge marital rape legitimises this, it was felt.

“At marriage, women promise to obey ...” (adult male, Nairobi)

“Biblically, when 2 people get married, they commit themselves including their bodies to each other. Rape really cannot arise” (Male, Christian religious leader, Interview)].

“...I believe there is no rape in marriage (pause)... that is my religion, there is no rape because I am supposed to take care of my wife and she is supposed to sit and wait for me... it is just part of her responsibility that she has to do that...” (Male, Muslim religious leader, Malindi, in-depth interview)

It was however, noted by many participants in group discussions (particularly adult males in all districts) that even though rape in marriage did not exist, there was need for consensus when deciding to have sex. Expressions used to reflect this need included:

‘come to agreement’ (adult male, Nairobi)

‘mambo ni maelewano’ [things are about understanding each other] (adult female, Malindi)

‘mutual understanding’ (Male, Muslim religious leader, Malindi, in-depth interview)].

Both male and female participants felt that sex was a marital right for men and women that neither parties should deny each other.

A male adult in Malindi felt that, rape in marriage was a '*problem of Beijing*' being in reference to the Beijing platform for Action that highlighted many critical areas of women's rights and brought them to the fore for discussion.

The payment of dowry was seen to give man rights over women, including rights to sex. While men can and should have sex whenever they wish from their wives, some participants felt that this does not automatically apply to women. In one FGD where there were divergent views, one participant was interested in knowing from the others whether women had similar sexual rights since marriage was supposed to be complementary. In response a participant asked,

“sasa wewe unafikiriaje bibi yangu atanifanya nifanye mapenzi nayeye? Kusema ukweli, kama sijiskii, hiyo siku hana bahati”, [now you, how do you think my wife will make me have sex with her, to say the truth, if that day I am not in the mood, then she is unlucky (adult male, Nairobi)].

There were divergent views on the debates on what constitutes marital rape, with no consensus nor clear definitions and divergent views as well. For instance, a participant noted,

“kama haujiskii na anasema anataka na mnastrugle si hio ni rape” [if you do not fee like it (sex) and he says he wants (in reference to a husband) and then you struggle, is that not rape? (adult female, Thika)].

Long discussions with diverging views also went on in some groups. Below is an extract of the male adult FGD in Malindi on the issue of rape in marriage.

Table 4.7 FGD extract: divergent views on rape in marriage.

Kahindi: “*sasa mimi kuhusu mambo ya rape, yule bibi mkishikana kwenda kadhi au padre kushikanishwa, mlíkubaliana kila kitu sasa huyu bibi kujakukataa hali na conditions zako vile unavyotaka, yule bibi sio mkweli sababu anafaa kuagree na wewe, pengine hawe na ile hali ya kawaida kama hiyo jihali ndiyo iko, basi unampatia wakati mpaka hali yake itakapomalizika lakini kama yuko sawa, sioni kisababu*” [now, for me with regard to rape, when you go to the Kadhi or Pastor and get married, you agree to everything. For this wife to refuse your terms and conditions that you want, she is not a true wife because she is supposed to agree with you. Possibly if she is on the normal condition (in reference to menarch) then you give her time until she is alright, and if she is fine, I do not see the reason]

Mwasho: “*Lakini kama kwa upande wangu napinga kidogo vile mwenzangu amesemma kwamba punde tu anapo lazimishwa – kuna wakati mwigine kina mama pengine ameshinda kazi au wacha mambo ya kazi ngumu- pengine yeye mwenyewe mili wake haujiskii, sasa pale ni lazime kuwe na maelewano baina ya mme na mke wakubaliane kuwa basi mi nikiwa sawasawa tutaendelea na shughuli*”...(interruption by) [but on my side, I will oppose what my friend here says – there are times when your wife, maybe she has been working all day or her body does not feel up to it (in reference to sex), now there is need for discussion and understanding between man and wife so that they come to a consensus...”] (interruption by Kahindi)

Kahindi: “*aaaahhh weee bwana – hawa akina mama saa nyingine hawaleweki. Ndio maelewano ni lazima, lakini pia kuna ile- wewe ndio lazima uendeshe mambo kwa nyumba ama itakua kila siku, ni mwezi*”....(laughter in the group) [aaaahhhh you! Sometimes you cannot understand these women. Yes discussions must be there, but there is your responsibility to take charge of things in your house or she will be on menarch every month...] (laughter in the group)

Ngama: “*...lakini sio hivyo bwana - ...tukileta experince hapa, na kwambia, mimi bibi yangu akiwa hajiskii kulala na mimi, atakuja na vazi lengine – yaani kanzu ya moja kwa moja – sawa abakie pengine awe na chupi yake ndgani. Lakini the moment ikiwa mimi na hitajiana naye anivalie lesu tu, aaahh mambo swari. Kama ajiskii na mimi najiskia nitatumia mbinu kadhaa kujaribu kumleta kwangu. Lakini hiii mambo ya rape..*”.[it’s not like that... if we bring experience into this, when my wife is not in the mood for sex, she wears a long piece dress and her pants underneath it. The moment I want her or she wears a lesu (1 piece cloth that is wrapped around the body), aaahhh things are fine. If she is not up to it and I am feeling like I want sex, it is up to me to use my skill to bring her over. But this rape business...”

Charo: “*Kulingana na vile huyu jamaa amesema, ni kumaanisha kuna maelewano na bibi. Tusema hajiskii hata na mbinu zako halafu kama twajijua sisi wanaume, utaendelea tuu. Si hiyo ni kumlazimish na hiyo ni rape?* [from what this guy has said, there is understanding. Let us say your wife really does not feel like it even with your skill, and as we men know ourselves, we just go ahead anyway and force her, is that not rape?] (2 participants interrupt to talk at the same time)

Ngama: “*...mambo ni maelewano...*” [these things are about understanding each other]

Kahindi: “*...hii maneno ya rape baina ya bwana na bibi – siyaelewi mimi...*” [this business of rape between a husband and wife- I do not understand...]

The discussion took an angle of rape in the family in instances such as incest and the moderator directed it towards discussing reasons for rape.

Where it was agreed that there was rape in marriage, it was often seen as circumstantial. It would apply if the woman was sick, very tired or the husband was drunk.

Greater divergence in views on rape in marriage was found among women groups in comparison to male groups. Adolescent groups particularly in Nairobi, also seemed to have more divergent views among themselves where some felt there was rape in marriage and some felt that this did not exist.

Perceptions of consent: An emerging perception from the discussion above is that women never say yes to sex even when they wanted it. This was reflected in both male and female groups across the different ages. Therefore men would see women's no as a yes to sex.

Where this was raised there was consensus in groups that sometimes women said no when they meant 'yes' to sex and therefore no was not taken seriously. This was reflected in male and female groups across the ages and the different regions. An adolescent from Thika had this to say.

"... if he is used to touching and you tell him no but you mean yes, you know- you are acting shy then you allow him to continue. This could mean you are encouraging him...a no should be a no not a half no, or yes. There is a girl friend of mine who got her-self pregnant by saying no. The man removed her blouse as she kept on saying no, then the man pulled her to a chair, later to the bed and had sex, as she said No but did not take action. A no has to be No –make a face that says no" (adolescent female, Thika)

In reference to consensual sex in non-marital relations, a female adult from Nairobi felt that girls did not know how to say no to sexual advances from men, as they were no longer taught such issues unlike in the past.

"...nani anafunza wasichana na vijana maisha siku hizi – hakuna. Sisi tulifunzwa na akina shangazi ndio tukaweza kujua vile tutaishi na vijana wenzetu..." [who teaches girls and boys about life issue - in reference to sexual advances - these days? No one. We were taught by our aunties and that is how we knew how to deal with our fellow boys (adult female, Nairobi)]

Both male and female adolescent groups both in Thika and Nairobi felt that there was need for more open communication between partners.

"if you are in a relationship with a man you should be in a position to talk to him as in you can sit down and believe you are adults and tell him. If you are not ready to do just tell him you are not ready if he does not understand you are with the wrong man" (adolescent female, Nairobi)

Rape in non-marital relationships: In 1 male and 1 female adolescent groups in Thika and Nairobi, and 2 adult groups in Malindi and Nairobi where rape by intimate partners in situations outside of marriage was discussed in-depth, it was often associated with circumstances in which 'the alleged' rape happened and was not viewed as rape. It was felt that women wanted 'it' (in reference to sex) or were inviting 'it' by putting themselves in situations where it was likely to happen.

"How can someone talk about date rape, ukienda kwa huyo mwanaume si unajua ni nini unaenda uko kufanya" [when you go to the man's house, you know what you are going to do there (adolescent male, Thika)].

2 male adolescent groups (in Malindi and Nairobi) felt that there was no rape in relations since being in a relation was tantamount to consenting conditions of the relationship. However, there were no discussions on who sets the conditions of this relationship.

An adult male group in Malindi felt that if girls did not want sex, then they did not need to be relations at all until they were married. An adolescent male participant in a Thika FGD felt that it

should be referred to as “*sex by intimidation*” since rape did not reflect the complexity of what went on in relationships and sex within relationships. Participants (both women and men) felt that girls are responsible for rape in relations could be summarized as said by one participant;

“... *girls put themselves in this situation and should not be blaming men*” (male adult, Thika)

A group of male adolescents in Nairobi noted that rape could well be abused in relations where girls would say they were raped even when they went to have sex willingly with their boyfriends. This they noted could be used as a method of exacting revenge on boys/men for whatever reasons hence, should not really be recognized in relationships. It was considered therefore very difficult to distinguish rape in relations.

There was general consensus on the existence of rape in relationships in discussions by female adolescents in Nairobi and Thika.

“*As you go with this man you totally love and you do not believe that he can harm you and then you go out, you drink but you do not get drunk just about then you go home, he rapes you*” (adolescent female, Nairobi)

Personal near rape experiences: It was felt that often men and particularly boyfriends ‘forced themselves’ on girls who were either too ashamed to say anything about it, or had found themselves in situations where they felt they were to blame. Some personal experiences were recounted:

“...*once I was almost raped but I saved my self by pretending to be sick. I was actually hissing and he thought I was dying. You know I went out with a girlfriend who had her boy friend. We went visiting one of the friends to the man. My friend and her boy friend decided to go and buy cigarettes since they both smoked. They did not return to the room that I was waiting for them. I was left with a stranger I refused to sit on his bed though he was insisting. The man became violent he told me he was going to sleep with me I either like it or not. The doors were closed. I started acting sick and he left me alone and started looking for...from that time I could not sit on a man’s bed and I could be left with a man in a house. I lived with that fear for 7 years then I was able to deal with it. I could not have a boyfriend because of the fear*” (adolescent female, Thika).

My boyfriend tells me he taking me out somewhere. I was O.K .he then tells me I do not have a jacket so lets go to my (man’s) place to pick the jacket then we go. There happened to be some of his friends, so he told me if I do not trust him his friends would accompany us. We went to pick the jacket and we found a friend of his in the house who claimed he was going to pick the girlfriend so that we could out all of us. He started forcing romance on me. You know I did not go there to romance I was not prepared. He actually tore my trouser zip and pinned me down on the bed. I was forced to close my legs completely. He stated asking, Ann¹¹ why are you behaving like this and I am your boy friend? I was like - you are raping me. He told me let me do just this because you do not want and you can leave me and I do not care. I told him I would like to take some water and he allowed me to go outside the house...I walked out of the house and left him. I do not see the man up to date. I cannot go to a man’s house without knowing that there is someone else. I have a phobia (adolescent female, Thika)

4.4 Reasons for rape – is it justifiable??

It was necessary to identify the perceived causes of sexual violence. Discussions were focused around what causes sexual violence, why it happens and whether it is justified or not.

Dress: The most controversial discussions in all groups revolved around mode of dress as a reason for rape. Women's dress described as *'provocative'*, *'tight'*, *'non-existent'* and *'transparent'*, in different groups was seen to be largely to blame for rape.

"What do you expect men to do when they see you in very tight clothing?" (adolescent male, Thika);

"Surely, those tight and transparent things girls want to wear are just asking for it" (adolescent male, Nairobi);

"kama msichana amevaa ile immodest dressing, si hiyo kuenda kutafuta wanaume tu?" [if a girl has worn those immodest clothes, isn't that going out of her way to look for men? (adult female, Malindi)].

Summed up in one participant's words,

"is it rape if a woman is dressed provocatively and makes your desires go up?" (male adult, Malindi).

Counter debates on this discussion questioned the expressed lack of self-control by men reflected in discussions on dress;

"what do you people mean? Surely sisi sio wanyama, tunaweza kujicontrol" [surely, we are not animals, we can control ourselves (male adult, Thika)].

'African tradition and dress' was invoked in both sides of the arguments. While some (both male and female groups) maintained that African traditional dress was *'respectable'* and *'non-provocative'*, a female adult participant in Nairobi questioned what sense of African dress was being referred to, since traditionally, most communities did not wear the contemporary clothes found today. With regard to dress, another participant (female adolescent, Nairobi) wondered,

"na wale watoi wa 1year, 5 ama 12 wanarapiwa, pia wao wamevaa provocative?" (and those children aged 1,5 or 12 years that are raped, are they also dressed provocatively?).

She also noted that Muslim women who wore *'Buibuis'* (the plain black garment worn by men as per Islam religious requirements) were also raped, and felt that dress cannot explain rape.

It was argued that immodesty or a sense of it often depended on one's background, with an example of differences in perceptions of dress by people from the rural and urban areas being noted in 2 group discussions (1 adolescent female in Nairobi and 1 adolescent male in Thika). People from the rural area may find a type of dress immodest which may be acceptable in the urban areas. An adolescent male group participant from Malindi suggested the need for the government to look into a code of dress for women and girls to *'encourage morality'*.

Drug use and abuse: Rape was also seen to be caused by drunkenness, either from alcohol or drugs and this was reflected in the different groups.

The media: 2 adolescent groups in Nairobi and 1 in Thika felt that the media was partly to blame. The media was seen as encouraging sexual desire that could lead to rape.

"All there is on TV is just sex, sex and more sex" (adolescent male, Thika, FGD), which was seen to encourage sexual desire that could lead to rape.

The role of myths that suggest that an HIV positive person will be healed through sex with a virgin were seen to contribute to rape especially of young children.

2 adolescent male groups felt that girls sometimes say no to sex when they want it and therefore can be 'persuaded' and force could be used in this persuasion if necessary.

"African girls say no when they mean yes" (adolescent male, Nairobi, FGD) was the explanation given for *'using force sometimes'*.

Male sexual desire: There was an implied responsibility on the part of women to satisfy male desire for sex, which if not satisfied could lead to rape as expressed in the female adolescents focus group discussion in Thika.

This implied responsibility was found in both female and male groups across the different ages in all 3 study areas. Below is an extract of a focus group discussion by adolescent female group members in Thika.

Table 4.8 FGD extract: sexual desire as justification for rape

Njeri: *"...a man and he is married and is with the house girl there and maybe the wife doesn't care about the husband (in reference to not providing sex), what is he supposed to do? He can rape the girl"*

Muthoni: *"so are you saying it is fine for the husband to rape the house girl?"*

Njeri: *"no, but somehow you have to see the other side of things"*

Muthoni: *"what side of things? (raising her voice) You know what, there is no excuse for rape"*

Moderator: *what do the others think?"*

There was divided feelings from the group where some felt there was no justification and other felt that it might be justified.

The 'desire' or 'urge' of men noted in other discussions as a reason why rape could happen.

"If a man has approached a girl for long and she has refused to have sex, then he may rape her" (male adolescent, Nairobi).

Questioned how the participant felt about this he shrugged. Some participants took issue with this and one noted;

"hauwezi kuenda around ukirape everyone who refuses kukupatia. Ni kama kusema manzi anikatae alafu?? [you cannot go around raping everyone who refuses to give you – in reference to having sex with you-(male adolescent, Nairobi)]"

In another group discussion a participant felt that

"it is ok if a man is provoked at the wrong time" (male adult, Nairobi)

Women walking at night was an example that was advanced. This sentiment elicited debate and discussion within the male adult group with clearly divergent views. While tolerance and acceptance of rape as a way of life, may have been expressed, these views were not wholly shared in all groups and some participants (both male and female) felt that there was absolutely no justification for rape.

4.5 What makes sexual violence invisible in Kenya??

It was necessary to know the support mechanisms in existence at the community and institutional levels that are geared towards dealing with sexual violence in the prevention to care continuum. In all groups it was generally agreed that sexual violence is often unreported and that survivors choose to deal with the effects and outcomes on their own at personal levels. In each group examples of alleged rape were given by participants. There were however, very few examples or instances in which the survivors sought help. It was acknowledged in all groups that reporting sexual violence to the police was a legal requirement.

Shame, stigma and blame: Sexual violence was generally unreported to the police or taken for attendance to hospital due to fear of shame and stigma since reporting means making it public. In all groups rape was associated with shame experienced by the person who was violated and continuously instilled by the community,

“hiyo matendo ni aibu kubwa sana” [those actions are a big shame (female adolescent, Thika)

It was also felt that women are often blamed for rape. This is often expressed in the questions they are asked and treatment they get from the police stations, their friends and families in the event of rape and therefore unwilling to report. All female groups and most male groups in all sites felt that treatment of those who report rape by the police was not encouraging reporting.

“You will be asked questions ambazo ni kama ni your fault, ...where were you going at that time? Ama what where you doing in that dangerous place?” (adult female, Nairobi)

This was reiterated and from one of the key informants can be summed up,

“It is clearly amazing how violated women are suddenly blamed for having put themselves in their situations, for having asked for it... everywhere they go, the hospitals, the police, the churches.... it is no wonder that women just don't report” (female, NGO manager, Nairobi, in-depth interview).

However, some participants felt that the police were doing a good job. It was noted in 2 female group discussions that it often depended on the particular police person whom the survivor found at the station as some were very helpful and supported the survivor.

Besides shame and stigma, girls may not want rape to become a public affair for fear of stigma and perceived consequences of stigma such as not being married. In a community where virginity may still be held dear, rape would be difficult to report. In reference to this a participant noted that rape will not be reported for,

“fear of loosing market with men” [meaning that they will not be able to get men to marry them (adolescent male, Nairobi)]

or because

“no one will want them” (adolescent female, Thika).

‘African culture’: Other reasons advanced for not reporting and the shame experienced by a rape survivor seemed to be based on ‘African values’ that were often referred to in different discussions. One participant noted that,

“For Africans, sex before marriage is a shame” (adult male, Nairobi, FGD),

Male rape: Discussions on sodomy highlighted key issues around the placement of women and mens’ sexuality in the Kenyan society in general. Sexual violation of men was considered a greater violation than that of women and also carried with it more shame;

“Sodomy is very shameful, even more than rape... you see hii ni kitu ambayo haitakikani kufanyika kwa mwanaume...” [you see, this is something that should not happen to a man (male adolescent Thika, FGD)].

An adolescent female participant from Nairobi narrated an incident where a man who had allegedly sodomized young boys (near where the participant lived) had been released from the police station and the public took it up to themselves to do something about him and he was stoned to death by mob justice. Some participants’ felt that it was impossible for an adult man to be sodomized;

“na kwani atashikwa wapi ndio afanywe hivyo?” [and where will he be held so that he can be done like that? (adolescent female, Nairobi)].

Reporting: Intimidation is sometimes used as a weapon to keep sexual violence quiet. This was seen to happen mainly when the assailant was a person known and often in a power position relative to the raped person as in the cases of incest and marital rape.

“Many are not willing to report to the police, mainly because they feel that they will not get justice and they are afraid of being attacked by their perpetrators... and it gets more difficult when these are people they live with or have to deal on a daily basis” (male key informant, NGO Nairobi).

Reporting to the police was identified in all groups as among the principle actions taken after an incident of sexual violence. There were mixed feelings about police action when sexual violence is reported. Some male and female respondents felt that the police are helpful. Most discussion centered on police attitude that was seen to discourage seeking help. Questions asked by the police are often humiliating were seen to increase the ‘suffering’ of the survivor (female adult, Nairobi). They may even accuse you of just trying to get an innocent man arrested’

“si alikuwa rafiki yako?...na mbona unataka kumsingizia?si nyinyi mnajuana tu?” [Was he not your boyfriend? Why do you want to plant crime on him?... you people know each other (adolescent female, Nairobi)].

2 female adult groups (Nairobi and Malindi) noted the possibilities of physical violence if one resisted sex in a marital situation or verbalized the use of force to obtain sex. Of clear concern was the repetitive nature of violence in these relationships;

“kama imefanyika once, it will happen again and again” (female adult, Nairobi)

In all groups various examples of sexual violence known to the participants to have happened showed a repeated pattern of sexual violence. Within relations it was noted that incest was often discovered after it had been on-going even for many years.

In every group discussion, participants had heard, were aware or knew people who were reportedly sexually violated by the police, either in custody or when they had been allegedly arrested but never got to the police station. A male adolescent recounted witnessing an incidence of rape by the police. The vulnerability of those who have been arrested highlights power relations between them and the police and how it can be dealt with or influenced. These also indicate a high level of mistrust of the police by the general public with regard to action towards sexual violence, which in turn influences the interaction between rape survivors and the criminal justice system.

4.6 What do communities say about sexual violence, HIV: linkages and effects??

HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) cannot be de-linked from sexual violence. The risk of HIV transmissions increases in sexual violence as seen from literature (section 3.8). It was therefore important to understand participants' knowledge of HIV and its links with sexual violence. All participants in all groups had heard about HIV/AIDS. Most information on HIV infection, transmission and progression to AIDS was correct. There were few participants who had incorrect information on HIV such as, HIV is transmitted through sharing towels or cutlery (adolescent female, Thika) with infected persons and on ARVs: if taken for 10 years can cure HIV (adult male, Malindi)

Effects of rape: Both female and male groups expressed immediate emotional stresses and reactions as the effects and outcomes of sexual violence. These included long lasting phobias, that were seen to affect relationships with the opposite sex thereafter and resulted in mistrust and withdrawal. The effects of rape by partners (boyfriends and husbands) and by family members or close family friends was discussed more in female groups and was seen to have most effects as it was often from the least expected persons and there were few places one could turn for help in such situations. In section 4.2 (personal near-rape experiences) on rape in relationships, experiences recounted by girls of near rape situations they have experienced clearly highlight some of the long lasting effects.

Resultant behavioural problems such as alcoholism and drugs and broken relationships were noted. These were seen to include divorce at times. Physical problems associated with sexual violence included bleeding, shock, vaginal wounds. Few participants, predominantly female (both adult and adolescent), highlighted the possibilities of infection with HIV, Sexually Transmitted Infections (STIs) and pregnancy as likely outcomes of rape. While participants noted that HIV is transmitted primarily through sex, there seemed to be no explicit connection between rape and HIV transmission.

Awareness on what to do after rape: Awareness of what to do if sexually violated was diverse. Some participants felt that the police station should be a first stop, others the hospital, others the chief's office for reporting. There was consensus on the need to go to the hospital. However, it was felt that services at the hospital were often lacking. There was limited personnel in hospitals, services were expensive for those who could not afford to pay cost-sharing fees and there were no counselling services available at the hospitals. Reference was made to the insensitive language of health care providers in the hospitals in words such as

“you asked for it” (Female adult, Nairobi).

Services that should be available for post-rape care identified included, counselling, physical examination and filling in the P3 forms (forms provided in police stations that are filled by doctors on examination of any assault cases). In 2 male and 1 female adolescent groups, there was reference to a process of 'cleaning' done at hospitals. This was vague and seemed to describe some unknown process undertaken in the hospital to clean the vagina. There was certainly no knowledge among the group participants on what could be done to prevent infection of STIs including HIV and pregnancy in the event of rape to avoid infection. Management of disease was seen to be possible after the establishment of infection when the survivor began to experience symptoms of any outcomes. A participant (adolescent male, Malindi) suggested blood transfusion to change the HIV status of someone who finds that they have HIV after rape, but noted that it was a costly and hi-technology process that had to be done out of the country.

There was no knowledge and/or awareness of the existence and use of post-exposure prophylaxis in particular. In Thika, a participant from a male adolescent group had heard about PEP and that it was available at the Nairobi Hospital (an exclusive private hospital), and would function within 24 hours

of exposure, and was not aware of the mechanisms of action. There were questions to the group moderators on PEP and its functioning from all groups. These were deferred to the end of the discussions when they were answered.

Questions most frequently asked by participants revolved primarily around PEP therapy:

- How PEP works,
- How sure the moderators were that it works
- How much the moderators know on the safety of PEP
- What advice the moderator would give about where people should report first- the hospital or the police station

The moderators answered these questions with facts on PEP and suggestions for referrals. On where people should report first, moderators provided information on the necessity for taking PEP at the earliest possible moment after rape.

In conclusion:

The objective of this chapter was to establish perceptions of gender based sexual violence from communities. The local understandings of sexual violence expressed in these discussions shape the dynamics of the environment within which sexual violence is founded, perpetuated and/or responded to. Social, legal and medical response to sexual violence and HIV in Kenya must be informed by these local interpretations. In particular, education, advocacy and information initiatives clearly need to be founded on these. The themes discussed in this chapter: rape and its context in Kenya, rape in relationships, reasons for rape, reasons for the invisibility of sexual violence in Kenya and what is said by communities on sexual violence emerged during analysis of focus group discussions. They form a basis for understanding and inform the development of a strategy for post-rape services provision. The next chapter is based on objective 3 of the study and analyses services currently available. It identifies existing gaps, challenges and opportunities as viewed by service providers again to inform the development of a comprehensive strategy.

CHAPTER 5 POST RAPE FACILITIES AND SERVICES

The primary objective 3 of this study was to document and analyse post rape services available in Kenya including the use of post-exposure prophylaxis. Information from this chapter is largely from key informants. Quotes in this chapter are from key informant interview unless stated otherwise. The chapter starts with textboxes providing a simplified overview of the findings. A textbox on the South African experience is provided, followed by a subsection on what constitutes ideal post-rape care services. Findings are divided into 2 main themes: health care service provision (section 5.3) and legal protection and criminal justice system (section 5.4).

Various methods were used for data collection (ref. Table 2.2) and are highlighted here to provide a clear signposting of the source of information for this chapter.

- Key informant interviews and informal discussions
- Workshop on ‘medico-legal treatment, examination and care of rape survivors in Kenya’.
- South African study tour: workshop, consultations and visits

5.1 Summary of findings

Table 5.1 Summary on health care services for rape in Kenya

- One rape crisis centre (Gender Violence Recovery Centre) at the **Nairobi Women’s hospital** was found to have comprehensive services (ref. Table 5.3). There was limited linkages and referral to legal protection and the criminal justice system
- There is an unclear referral system in health institutions. All public hospitals visited had different systems of post-rape service provision, that were also not clear with different members of staff
- Costs varied depending on the status of the institution
- There is a lack of policies, operational guidelines and procedures as well as national standards for post-rape care.
- Forensic examination is not understood or well undertaken
- Samples often involve testing for the presence of semen and the presence of STIs
- Limited PEP provision, limited capacities for ARV administration. PEP was available for sexual assault in 1 institution and for occupational exposure in 2 institutions
- Often services offered depend on the doctor or clinician providing them
- Counselling services are ad hoc and unavailable to rape survivors in public institutions
- Rape survivors are increasingly being sent to VCT for counselling

Table 5.2 Challenges to post-rape services provision

National level: Lack of national standards and protocols, no policy guidelines and regulatory framework on post-rape care

District/institutional levels:

- Long queues clients have to make – in consideration of PEP
- Lack of data for planning and information as sexual violence is recorded as ‘assault’
- Limited number of doctors with limited capacities for ARV administration & management
- Lack of counselling services except VCT in hospitals
- Lack of a chain of custody of evidence – police do not sign for specimen
- No referral systems between different services providers

Table 5.3 Legislation and the criminal justice system

- Poor legislation that does not cover all aspects of sexual violence/abuse
- Existing legislation is poorly enforced
- Unclear chain of custody of evidence
- Doctors are reluctant to appear in court
- Police capacities in dealing with rape survivors and management of evidence is limited
- There are no links between medical, legal services and the criminal justice system

Table 5.4 Post rape health care services available

This table highlights in summary form the health care institutions visited during the study and the services that are availed by each of these institutions.

Institutions	Status	Cost	STI prophylaxis	PEP	ECP	Coun-seling	On-going	VCT
Nairobi								
Nairobi Women's Hospital (GVRC)	Private	Free						
Riruta health centre	Public	Pay for card	-	-	-	-	-	
Kenyatta National hospital	Public	Pay for card		-	-		-	
MSF France - Mathare	NGO	Free		-	-			
Marie stopes Eastleigh	Private	Charge	-	-		-	-	-
Thika District								
Plainsview hospital -Thika	Private	Charge	-			-	-	-
Thika district hospital - Thika	Public	Pay for card	Syndromic management		-		-	
Igegania health centre - Thika	Public	Pay for card	-	-	-		-	
Malindi District								
Malindi district hospital	Private	Pay for card			-		-	
Marie stopes - Malindi	Private	Charge	Syndromic management	-		-	-	-
Malindi medical centre	Private	Charge		-	-	-	-	-
Women's rights awareness programme	NGO	Free	-	-	-			-

- The Nairobi Women's Hospital is the only institution that offers free comprehensive services for post rape care
- Thika district hospital, Malindi district hospital and Malindi medical centre provide PEP primarily for occupational exposure
- Public health institutions charge clients for registration cards that are used for recording purposes on examination and treatment

- Private health service providers charge commercial rates that vary for the different services¹².

¹² It was difficult to establish the specific charges in this study as it was said to vary and depend on the different types of services offered. For instance, charges for STI treatment would depend on whether screening was done or a routine

Table 5.1 The South African experience

Challenges in the South African experience of post rape care services

1. Infrastructure for service provision was not well developed when implementation was rolled out posing logistical and operational challenges
2. Collaboration and coordination of stakeholders – justice, police, home-affairs, health services and NGOs is poor resulting in uncoordinated service delivery. An example of networking and partnerships was provided of the ‘Hands Off Our Children’ programme that aims to eliminate sexual violence on children. Committees around the districts each have representatives from relevant local agencies, including judges, magistrates and NGOs working together. While no evaluation has been undertaken, a social services official felt that in 2 years there has been increased reporting and a drop in levels of sexual violence against children.
3. PEP poses challenges:
 - Finding out ones HIV status at this time of trauma;
 - Wider social implications of an HIV test – marital status, family structure etc;
 - Misconceptions about PEP as treatment for HIV/AIDS;
 - Limited capacities for ARV administration and management among HCWs;
 - Adherence problems to drug regimens and limited follow-up for both counseling and PEP.
4. There is an increasing use of ‘one-stop rape crisis facilities’ where all services are provided within the same place. This is most common in hospital settings. Police are available for reporting, examination, counselling and legal support is provided.
5. Training offered depends on the target group and need being addressed and aims at all post-rape care service providers. Challenges include the quality of training provided,
6. There are currently limited links between VCT and sexual assault. Counselling for HIV/AIDS particularly in the context of rape is not well established even in the designated rape crisis centres. A conscious awareness of rape/HIV/AIDS linkages is only just emerging among HCWs and the general population.

Source: compiled from key informant interviews, workshop discussions and rape crisis site visits

5.2 Ideal post-rape care services

Post-rape services can be divided into 2 broad categories of health care services and legal support and protection, which ideally should work hand in hand and include the following:

Health care services:

- Counselling: for crisis prevention, ongoing emotional support of the survivor and their families
- Clinical care: physical examination and treatment, STI/HIV and pregnancy prophylactic treatments, evidence collection from survivor and documentation
- Sample handling and analysis: Laboratory analysis and documentation. It is this process that links to the legal support and protection services.

Legal support and protection:

- Statement recording, evidence collection from scene of crime,
- Preservation of the chain of custody of any evidence collected
- Arrest and prosecution of assailants, meting justice
- Legal and judicial support for survivor

Information on post-rape services and facilities available was acquired from key informants and from participants at a ‘*medico-legal workshop on forensic examination, treatment and care of rape survivors in Kenya*’.

5.3 Health care service provision: services, systems and processes

In Kenya, every district hospital is supposed to be able to provide post rape services including links to the local police stations. While any legally registered physician in Kenya can collect evidence and undertake documentation of rape, ideally this should fall within the docket of a police surgeon who should be available in every police station. However, there is currently only 1 police surgeon in the country who is available only in Nairobi who is assigned to undertake a physical examination, filling out P3 forms¹³ and overseeing legal/justice processes for survivors of sexual violence.

Services and costs: In Nairobi, various aspects post-rape care services were found to be available in almost all private health care institutions. According to key informants most hospitals provided physical examination, evidence collection, physical care and an increasing number are providing PEP. Often in these institutions, survivors of sexual violence would need to pay for services availed. While some provided counselling and emotional support, others referred their patients to institutions offering counselling care and support. The cost of services was found to be dependent on the institution with no specific government guidelines on the same. These often included consultancy fees (charged to see a physician), fees for the different tests necessary and 1 institution was found to charge for filling of the P3 form (though the cost could not be established). The rationale provided was that, if this matter was taken to court, it would cost the doctor time and money to be in court and give evidence.

There was 1 health care institution that was found to provide free post-rape services including post-exposure prophylaxis - included the Nairobi Women's hospital, (a private institution) supported primarily through donor funding for the service. The Kenyatta National Hospital (KNH - Kenya's principal referral hospital) was seen to provide PEP depending on the availability of drugs. In these institutions, there are no fees paid for post rape services, with exception of a fee to pay for 'a card' (money provided for the access of a card used to enter one into the system) at the KNH. The cost-sharing requirement applied to all other services at the district hospital has been in the past applied for rape survivors as well¹⁴.

Registration processes: In the Districts of Malindi and Thika, there were limited post-rape services available. At the District hospital (public institutions), survivors of sexual violence are often attended to in either the outpatient department (OPD) or casualty if they arrive outside of the regular 8.00am to 5.00pm working hours. The system often involves, queuing to get a hospital card and paying for it, waiting in the patient queue to be examined by the doctor or clinical officer. At the point of getting the card, an explanation needs to be made to the clerk entering the register, in order to record this. In the public hospitals visited rape is recorded as 'assault' and can therefore not be differentiated from other forms of assault. Processes at public hospitals require that the survivor recount their event to several people; recording clerk, clinical officer or doctor, laboratory technician and counsellor. Repeating their experience is humiliating. Confidentiality is not observed.

With regard to queuing, a rape survivor has at this time experienced the most traumatic event that leaves them feeling violated, ashamed and will in the short term experience disorientation, confusion (Dey, 2002). Waiting in a queue will exacerbate these feelings and helps loose evidence that disappears with time.

¹³ P3 forms are legal document found in police stations that Doctors fill on examination of rape survivors (and in other assault cases) and used as medical evidence during investigation and prosecution processes to prove, corroborate or at times dismiss the assault case. They therefore form the basis of investigation, a crucial part of evidence and documentation.

¹⁴ However, this has currently changed with efforts to treat rape survivors as emergency patients and provide them with free services where they cannot afford are being undertaken in the District hospitals of Malindi and Thika, where LVCT

In one case study

‘in 2002, an 18-year-old was raped by her family friend and visited the hospital on the same day but as the queues were too long so she preferred to go back home and return the next day. Unfortunately she was not attended to and finally went to a private hospital after three days. The HVS test was done and no spermatozoa was seen but no gram stain (colouring used in a lab to highlight presence of bacteria and spermatozoa in a specimen) was done’ (Forensic pathologist, Nairobi).

Forensic examination: After a physical examination, the examining physician will collect the samples (high vaginal swab – HVS) from the survivor and send this to the laboratory. The survivor may also be sent to the laboratory to present other samples such as urine or blood if necessary. The survivor may then be sent to the laboratory to pick up the results. The only exception is if the requirement was a HIV test, then the hospital staff pick it. In some instances, the police officer may be allowed into the room when the physical examination is being undertaken. The examining officer (if they are a doctor) will fill in a P3 form (in the case where the survivor has reported to the police) and this will be handed to the police. The survivor is then required to wait for the results. They will often be encouraged to report at the police station.

Physical examination is a necessity in the event of rape. It was described as
“a difficult experience” (female clinical officer, Nairobi)

for both the survivor and the examining officer, since most officers were not sure how to deal with survivors of sexual violence. It involves examination of the perineum including the genitals. It may require the insertion of a speculum or other instruments in the vagina or anus. For the person who has just been violated, these processes may result in ‘secondary trauma’ or ‘second rape’ experienced and will require counselling and emotional support that is often unavailable at these hospitals.

Documenting medical evidence: In the event that the examining physician is not a medical doctor, then they cannot fill in the doctor’s report (P3 form) that is provided at the police station. This is because it is only doctors, who can act as expert witnesses in court and therefore are allowed to fill in this report. Ideally, the doctor would be the best person to undertake examination and treatment of the survivor. However, this requirement is constrained by the limited number of doctors available at the district and sub-district hospitals who often have to deal with other pressing emergencies and life saving situations. In these situations, key informants noted that doctors’ priorities will often therefore not lie with a survivor of sexual violence. To solve this problem, an examining clinical officer writes out a report, that a Doctor then transfers onto the P3 forms and may appear in court. Key informants noted that this system had various shortcomings:

- The expert witness (doctor who filled the P3 form) may be unable to adequately provide evidence in court since they did not undertake the examination
- This creates an additional bureaucratic loop at the health care provision level
- Much evidence may be lost in the transfer of data between the clinical and medical officer
- Some clinical officers were not familiar with required examinations and even filling in of the P3 form.

Current P3 forms used to record assault were seen to be lacking in detail and unable to be used to adequately record information necessary for use as evidence in sexual violence cases (at the medico-legal workshop). It was noted that a protocol for examination of rape survivors, and a document for recording has been developed by the Kenya Medical Association (Human Rights Committee) in collaboration with the Independent Medico-legal unit in Kenya. It has so far been proposed that this document be institutionalised to replace the P3 form and has been forwarded to the Attorney General’s chambers for review. One key informant noted that, it had been reported to them that the

protocols were already being piloted to assess their practicality in different areas. It was not clear where pilot testing this was on-going. However, from interviews in all areas, no one in the Districts or in private institutions interviewed had seen the protocols or used them, neither had they accessed the examination kit that was proposed alongside the protocols. Further, most institutions providing services did not have any written protocols in place nor did they have a national reference.

Counselling services: If a diagnostic counsellor is available at the hospital, they may provide counselling to the survivor. While this is the requirement in district hospitals, many do not have diagnostic counsellors and in some places where they are present

“they are not actively practicing and this is usually just another add-on job” (female nurse/counselor).

It was noted by a medical officer in Malindi that survivors of violence are increasingly being referred to VCT counsellors for emotional and psychological support, as these are the only such services available within the district hospital.

PEP, Emergency contraception: Treatment and provision of drugs depends on their availability at the district hospital. It was noted by key informants that drugs are often unavailable to be given out and were prescribed for patients and survivors to purchase. Discussions with key informants and from semi-structured sheets on post rape care services provided to most health care service institutions revealed that clinical management of rape survivors often included:

- a physical examination of primarily the perineum with little attention to other body parts, unless there were injuries;
- A high vaginal swab (HVS) was always taken and sent to the lab where a wet prep was prepared to check for spermatozoa (often seen as key to evidence collection of rape).
- An STIs test

There was limited consideration for the provision of emergency contraception (ECP). Only 3 of the institutions visited offered emergency contraception. At the Nairobi Women’s Hospital, this is routine.

The fear and anxiety of HIV infection from sexual violence has become of increasing concern. This has been seen in the increasing number of VCT clients who are presenting rape as expressed by VCT counsellors. However, there is little done to avoid HIV infection during post-rape care in most public health institutions. Post exposure prophylaxis is a term that all medical doctors interviewed were familiar with. However, many were not clear about the functioning and mechanisms of ARV action for HIV prevention. For many other health care workers in both public and private institutions, little was known about PEP – its availability and functioning. PEP was only available in the Nairobi Women’s Hospital and is provided to survivors after examination HIV testing. While this would be a requirement for PEP administration, there have been concerns expressed about how much information a survivor can accommodate at this traumatic time and how much of consent for a HIV test would be informed (Medico-legal workshop - Kenya/PEP workshop SA).

“how does one deal with HIV at a time when they haven’t even began to deal with rape, as a person and from a family point of view?” (participant, NGO representative Nairobi at the Medico-legal workshop).

From a private institution, who attended 5 survivors of rape and sodomy (4 female and 1 male) in the year 2002,

“we do not offer more than treatment for STIs and sometimes recommend emergency contraception...we really haven't thought about HIV” (clinical officer, Malindi).

Of concern here is the slow response of some health institutions towards HIV and the quality of services offered for post-rape care. Key informants noted the lack of a policy framework and national guidelines within which to provide services. This resulted in ad hoc services, that are not standardized and

“that often depend on the doctor providing them” (medical doctor, Nairobi).

Post rape services provision would therefore need to be regulated in a way that ensures that survivors get comprehensive services.

Key informants noted the lack of information and updates on medicine. A medical officer in Nairobi however felt that

“there is a lack of a reading culture even among us physicians, so we do not keep ourselves updated. Things are only beginning to change”(Medical Doctor, male, Nairobi).

There was general consensus from key informants in medical care that there was limited capacity among medical practitioners and health care workers on management of sexual assault and with regard to ARVs, particularly PEP administration and management. Baseline tests (including renal and liver functions tests) were found to be taken by one public service provider before administration of PEP. The District hospitals lack capacity in information, skills and facilities to undertake the tests and manage PEP. PEP has been known to be toxic and there has been evidence of side effects (section 3.8.1) making close monitoring a necessity.

Challenges cited by post-rape service providers in health care included the lack of resources to provide the required services with more reference made to the lack of funds to buy drugs, reagents to undertake necessary tests or procure necessary care consumables. The lack of resources was also experienced at personal levels where it was noted that many rape survivors were unable to access services since they could not afford to pay-up the required fees. This echoed the perceptions of participants during group discussions who felt that services within hospitals were expensive for people who could not afford even a decent meal. It was also noted that rape was often unexpected and did not always occur when a person had money, making it harder for survivors to access post-rape services.

5.4 Legal protection and the criminal justice system

It was necessary to understand the legal requirements in the case of rape, what actually happens and people's perspective of what should happen. It was also necessary to establish other services provided to enhance the quality of life of the survivor or to their access to justice.

Ideal services: In the event of rape a survivor is expected to report at the nearest police station from where recording is done, they are given a P3 form and accompanied by a police officer to the hospital where they are examined, treated and the police officer goes back with the P3 form and any evidence from the survivor. Ideally, a police surgeon who then fills in the P3 form should see them. This then becomes an open case and an investigation is commissioned. When and if an alleged perpetrator is caught, a litigation process begins where the judiciary is supposed to provide a state prosecutor for the survivor who should avail themselves as the defendant in court. The court passes a judgement and gives a sentence. While this was seen as the ideal situation, obstacles were seen to the process and the system.

Legal provisions: Rape is captured within the Kenyan constitution as part of the penal code. A comprehensive legal definition of rape was seen to be lacking. Key informants observed various shortcomings in the present legislation including:

- Rape in Kenya is occasioned by penetration of the penis to the vagina only. This was seen to exclude sodomy, the use of items such as bottles thus limiting. Any form of sexual violation of the anus (both women and men) is therefore not legally recognized as rape¹⁵. In the legal system, there is no formal exclusion to marital rape since no legislation has been passed providing that it is not illegal to abuse a wife sexually. Further, laws developed to punish sexual violence/rape tend to exclude sexual violence in marriage.
- Rape was seen to have a clearly defined maximum penalty (life-imprisonment) but with no minimum sentence. This was seen as a challenge for lawyers and for new cases in courts especially when old cases had been given minimum sentences.
“... the bench often bases judgements on precedence. Considering the kinds of sentences rape has been getting, from probation to fines of as little as Ksh.10,000.00 (approx. US\$130), it becomes very difficult to get different convictions...” (Lawyer, NGO programme officer, Nairobi)
- Evidence of the long term effects of rape and sexual violence on survivors was seen to be missing, often from the medical background presented in court of the survivor as well as in published research as evidence to support what the survivor goes through.
“... the challenge of showing the psychological problems associated with rape when there are no physical injuries is very real. Besides, we really do not have psychological services targeting rape survivors and is probably the reason we have limited evaluation to go by... it's quite tricky to present 'destroyed quality of life and self-worth' to the court” (Lawyer, NGO programme officer, Nairobi)

Linking medical evidence and the legal system: for prosecution of rape cases was seen to be a major challenge in Kenya. Key informants noted that evidence was often not collected because;

- Survivors did not know what to do and often destroyed evidence of rape by ‘taking showers’, not reporting for a long time (2weeks to 6 months from the time of rape), washing or throwing away clothes worn during the rape
- Medical personnel (those undertaking examination) were unaware of the details that could connect the crime to the survivor. The only thing often reported was the high vaginal swab (HVS) results (with regard to spermatozoa in the vagina) hence increasing difficulties in prosecution. Principal to the reliance on HVS is the assumption that spermatozoa are a definite indicator of rape. It was noted that the presence (or absence) of spermatozoa in the vagina has often been used “as a yardstick” for evidence of rape or/and that there have to be injuries in the vagina if rape really occurred. This was seen as incomplete and a key informant noted some of the key shortcomings with these assumptions:
“supposing the raped person is married and had sex with their husband a day, 2 or 3 before the rape? Unless you then have a DNA test to show whose sperms those present in the wet prep are, you cannot use that as evidence, any lawyer will trash it”
and with regard to injuries,
“there may be no injuries at all. For instance it is highly likely that a para3 (a woman who has had 3 births) will show no signs of injury to the vagina” (forensic pathologist, Nairobi).

¹⁵ By the time of doing a final draft of this report, the Criminal Law Amendment Bill had been passed in Kenya (in

- Doctors were also seen to be reluctant to sign up P3 forms since it made them expert witnesses and many were unwilling to go to court.
“there is often such scanty evidence and lawyers know each loophole in the system that often doctors are embarrassed in court and they have become increasingly unwilling to sign P3 forms.... In any case, this should be work of the police surgeon” (Clinical officer, Nairobi)
- Key informants, both lawyers and doctors noted the need to build the capacity of doctors in collecting evidence from survivors in a way that can be used to build a case in the future. Capacities were critical issues arising from evidence collection at the point of examination.
“Doctors and clinicians need skill and training in proper examination and it’s importance in rape cases. This will enable them take evidence and preserve it adequately” (Medical Doctor, Malindi)
- There is the lack of a clear legal procedure and lack of information by the public on what to do. Often there is lack of evidence means that the court may be unable to met justice.
“evidential requirements are very strict here (in Kenya), and more often than not, we simply do not get any evidence. In fact, it is almost always a case of the word of the defendant against the word of the accused and it becomes difficult to do justice in such cases” (Magistrate, female)
- Lack of evidence was seen to be a result of the police as well. Investigations were seen to be poorly carried out and the police rarely followed up on rape cases. It was seen to be the job of the police to place any evidence collected in safe custody for presentation to the Government Chemist from where analysis is supposed to be undertaken. The ‘chain of custody of evidence’ is generally broken with no connection between the police in the Districts and the Government Chemist. It was acknowledged that in Nairobi, there are many more samples and evidence that end up at the government chemist than from other districts.

The Judiciary: There were other barriers noted that compound the problem of lack of/limited evidence. These were seen to influence enforcement of legislation, determine ability or wish of those who have been violated to report and affect the way rape in general is dealt with.

- Survivors are often unable to initiate speedy criminal proceedings due to stringent rules requiring consent from the Attorney General prior to the prosecution. This makes the survivor go through the violation for a longer time. Further, in cases of incest where the perpetrator is significant to the defiled/raped person, it becomes even more difficult to initiate prosecution since contact will continue to be made. The lack of shelters for women who are violated especially from their homes was noted as a key challenge to rehabilitation of rape survivors. There is currently one existing shelter in Nairobi, supported by the Women’s Rights Awareness Programme (WRAP) that caters for clients for only a limited amount of time.
- Often hearing of court cases is done in public. This means that the survivor will have to recount their story and be cross-examined in public. A key informant stressed on the need for closed hearings.
“...(this) would provide some confidentiality and a sense of privacy to the client. Can you imagine the prospect of recounting in details what may have happened to the public. Where criminal proceedings have gone to court, which is rare, I have seen a client go into depression from that process...” (NGO programme officer).
- Magistrates were seen to have a role in providing a safe environment for the survivor. One key informant noted that there has been increased sensitivity by some members of the ‘bench’ towards rape survivors since training was undertaken for them on rape. However, there have

been instances when the survivors have been re-traumatized by the event due to the decision of the magistrate.

“...for instance a certain magistrate insisted on a child giving her evidence in a defilement case in public the magistrate claimed that it was not a children’s court and hence there was to be no luxury of hearing the trial in private”(NGO programme officer, Female)

While sexual violence is clearly a criminal offence and is punishable by law, there were parallel, existing systems seen that met justice where rape and violence are concerned. It was noted that the provincial administration was often called in to preside over rape cases particularly where parents and children were concerned. Other systems were seen to include traditional seating such as the clan system. These systems are dominated by men as the decision makers and were described as

“a great hindrance to justice” (NGO programme manager, male),

“a major obstacle to dealing with rape”. (NGO programme manager, female)

Often the accused are asked to pay penalties and fines that range from a chicken, goat, a few hundred shillings or even forced to marry the girl whom they abused.

One key informant noted the need for the Ministry of Health and the Ministry of Justice and Constitutional affairs to establish collaboration to build forensic examination in Kenya. She noted that this would support the development of services not only for rape in Kenya, but other crimes as well.

Reporting challenges: While reporting was seen as essential to enhancing the visibility of rape, dealing with stigma and enhancing the just process, it was seen to be largely not done. Key informants seemed to corroborate information from the focus group discussions, where the reception of the police was seen to largely discourage reporting.

“...reporting to the police is most survivors’ worst nightmare... Police often tease and are not empathetic to the survivor, they do not see sexual violence as important and often tell jokes about it. Confidentiality in the police stations is not provided to the survivor. Even with the gender and human rights training that has been introduced by a number of human rights organizations including FIDA - K, police officers still taunt survivors. Some even tell them that they cannot record statements or issue P3 forms if there were no witnesses present, while it is clear that in rape, there is hardly any witness present...”(Senior NGO worker, Medico-legal workshop, Naro Moru)

This was seen to reiterate feelings expressed by participants in focus group discussions – both female and male, across the different ages.

a major challenge identified by the police with regard to service provision has been that of capacity among the police force particularly the service providers.

“all these NGOs concentrate their training on rank officers, yet the people who actually provide the services and need to be sensitised and the junior officers” (police inspector, Nairobi)

In conclusion:

The objective of this chapter was to analyse post-rape care services and facilities available in Kenya. Post-rape care services available were identified and categorized broadly into 2; Health care services and legal support and protection. Gaps, challenges and opportunities for service provision have emerged in these findings and those on community perceptions (chapter 4). They are explored within a larger framework of gender power relations (as a cross-cutting theme that emerged during analysis of the findings of this study) in the next chapter. The effects and interactions of gender power relations on information access and use, social norms and values and institutional responses to sexual violence form the basis of discussions.

CHAPTER 6 DISCUSSION OF FINDINGS

In this chapter discussions are pulled together from literature (chapter 3), findings from focus group discussions (chapter 4) and key informants (Chapter 5) and my own experiences relevant to the findings of this study. The chapter starts with summary text boxes of discussions. An overview of the gender, age and geographical diversities from data is provided (section 6.2). The overriding theme in this chapter is that of gender norms and power relations. Following subsections analyse the dynamics and interactions of gender power relations with: information use and access (what is known and what can be expressed – section 6.3) and social norms and values (women’s agency, perceptions of femininity and masculinity and contemporary society and the concept of ‘*African culture*’ – section 6.4)). Institutional responses to sexual violence (social, legal and medical) are also explored within the same framework (section 6.5). Differences emerging during analysis by gender, age and geographical regions have been teased out where applicable and their implications discussed. During discussions, reference is made to various sections of the literature and study findings that are bracketed.

6.1 Summary of discussions

Table 6.1 Gender power relations: information- access and use

- There is lack of consensus in definition of terms and contexts that highlights differences in local understandings and interpretations of sexual violence. They are more distinct by gender and less by age and location. They present implications for information, education and communication on HIV/AIDS and medico-legal responses for sexual violence in Kenya.
- Gender related access to information influences its use and application
- Further inquiry into the existence of traditional methods of sex communication and their application to contemporary education could potentially influence awareness on sexual violence

Table 6.2 Gender power relations: Social norms and values

- Reporting, seeking care and support and institutional response to sexual violence is influenced by:
- Women’s agency with regard to sexual violence in a given society. (Presented here are opportunities for further research)
 - Perceptions of femininity and masculinity that present contradictory expectations about sex and sexuality for women and men
 - Women’s perceived responsibility to fulfil men’s sexual desires especially in marital relations
 - Restrictions in time, space, movement and dress in society particularly for women and girls
 - The media’s objectification of women’s bodies in promoting commerce and trade

Table 6.3 Gender power relations: Social medical and legal response

- Legal considerations for individual rights are often outweighed by social restrictions and expectations of women and men
- Gender power relations that influence social norms and values are reflected at response levels in:
- Institutional barriers to reporting sexual violence
 - Lack of prioritisation and limited attention given to infrastructure in post-rape service provision by the medical and criminal justice systems
 - Time, resource and information constraints faced by women are not considered in health care delivery

6.2 Gender, age and geographical diversities: an overview

During analysis there was a distinct positioning of groups by gender and less distinction by geographical and age.

Gender differences: More debate was seen in male groups and specifically adolescent groups than in female groups in general on sex and sexuality. Group interaction among male adolescent groups was more active with less prompting from the moderator in comparison to female adolescent groups. There were least discussions from female adult groups, with the discussions in Malindi being almost similar to a group interview. Both groups of commercial sex workers (in Malindi and in Thika) were seen to be least interactive. They were composed primarily of women and girls with low literacy (mainly primary school drop-outs). It is not clear how far this may be co-related to the limited discussions experienced in interactions with these groups. Sexuality and sexual organs are treated a lot of secrecy (in general for all groups) and are not referred to by their names in public and sex seemed difficult to discuss. Women's groups however, talked and interacted less on issues of sex and sexuality.

Geographic differences: Groups in Malindi reflected less tolerance for diverse sexual orientation although all group participants were aware of homosexuality and lesbianism. It is also in Malindi that female participants were least open to discussions. This could possibly be due to Islam influence that has a more closed sexual culture than Christianity. Sexual culture can be defined by the attitudes, norms and practices in relation to sexual activity that exist and values that are promoted in the community (Kibwana & Mute. eds 2000). The lack of expression of sexual activity and limited knowledge of issues around sexuality experienced in groups discussions, seems to suggest a closed sexual culture. While all female groups in Nairobi (both adolescent and adult) were clear that rape is a crime with no justification, this was not the case for Malindi and Thika. While in Malindi there was a consensus that rape does not exist in marriage, there were divergent views within the groups in Thika and Nairobi.

Age differences: Adolescent groups in general were more interactive in their discussions and required less prompting from the moderator. Differences in opinions were more openly viewed in adolescent groups with potential for engaging arguments as participants took opposing views (for instance in section 4.4). There was more interaction between male adolescent groups than female. With regard to geographical differences, adolescent females from Malindi were the least open in discussing sex and sexuality. This may be attributed again to the influence of Islam that has a strict code of dress and expression for women particularly on sexuality issues. While adolescent group participants in Nairobi and Malindi were familiar with concepts of homosexuality and lesbianism, in Thika this was different. A possible explanation may be found in the cosmopolitan nature of Nairobi as a capital city and the influence of tourism and in-migration in Malindi unlike Thika. There were no marked differences in perceptions of boys and men in Thika and Nairobi.

6.3 Gender power relations: Information- access and use

Confusion between rape, sodomy and homosexuality was seen in almost all groups as reflected in section 4.2. It is not very clear the extent to which apparent understanding of the terms rape and sodomy may have influenced discussions, nor the emergence of new words and concepts of sexuality by participants. The words rape and sodomy were used distinctly based on the Kenyan law where rape refers to penile-vaginal penetration. Penile-anal penetration has often been referred to as sodomy hence the need to use the two terms in understanding community's perceptions and understanding of sexual violence. It is also unclear in how far the selection and use of these words may have influenced data collected. Discussions however highlight no consensus in the definitions and contexts in which the terms are used and this may be due to the way in which sexuality is perceived in the different areas by different people.

In general, women groups were less open to discussing issues of sex and sexuality and some were uncomfortable with the discussions or unwilling to discuss rape. One interpretation for this may be found in the place and nature of groups used during the focus group discussions. While women may well be informed on sex and issues of sexuality it may be socially unacceptable to discuss these in certain settings such as were found in the focus group discussions - people who do not know each other and the setting is formal vs in natural groups. For instance, in the Coast of Kenya, among the Swahilis, 'kungwes'¹⁶ are elderly women, who in the traditional setting, imparted sex knowledge on young women. Discussions on sex were extremely intimate in women only groups and often the group members were/are familiar with each other. Use of focus groups where participants may not know each other *visa viz* discussions in natural groups could have negatively influenced women's ability to openly discuss sex and sexuality in this study. One may begin to question whether traditional sex education practises still take place in different communities and, whether HIV and violence feature in the issues covered. It may even be important to inquire further into the existence of equivalent traditions in other Kenyan communities and the possibilities for interventions that build on such traditional forms of communication.

Another interpretation to women being less open to discussions on sex and sexuality is that women have limited information on sex and sexuality issues particularly around the different sexual orientations and this would infer gender related access to information based on norms and expectations for women and men. As Gupta & Weiss suggest (1993), femininity in many cultures dictates that "good women" be ignorant of sex and passive in sexual relations where overt seeking of knowledge may be construed as promiscuity.

Adolescent groups clearly emerge as more open to discussion and communication about sex and sexuality issues. There are gender differences in the levels of the openness and group interactions with male adolescents expressing more interaction as well as information, for instance in discussion on different sexual orientations. While this difference could be an influence of various factors such as geographic location, gender related access to information on sex and sexuality is once again presented.

Differences in information access and use by age raise some key questions: *Is the openness in discussing sex and sexuality by adolescents an attribute of changes through time?*

- a. If so, what would be the influencing factors? For instance, what is the role of the media (mentioned in section 4.4) with regard to sexuality and how can this be used to change attitudes that promote and perpetuate sexual violence?
- b. Are these changes therefore permanent or may these adolescents develop a more closed sexual culture as they mature into adult hood?

Suggested changes through time could be related to dynamic experiences of gender identities noted by Geles (1998) (section 3.6). Whether temporary or permanent, these changes present a window of opportunity for impacting values and attitudes that could change the foundations of sexual violence. The gendered nature of the access of information and its application emerges as being localised. The dynamics that perpetuate sexual violence are founded on these understandings and interpretations making local knowledge fundamental to policy and programming for sexual violence in the prevention to care and rehabilitation continuum. For instance, reporting sexual violence that is key to legal action (prevention and care) (seen in sections 5.4) will well be influenced by the ability to express oneself clearly and coherently about abuse.

¹⁶ Kungwe's are elderly women among the Swahili who played a key role in initiation and sex education. They existed

6.4 Gender power relations: Social norms and values

Women's agency: In non-marital relationships (both platonic and sexual) there were fuzzy boundaries on rape. If a girl or woman is raped, she will want to cover it up. This is for fear of stigma associated with rape and also due to social sanctions on non-marital sexual relationships for women but often not for men as in findings in section 4.4. The very expectation of men within the same community to be aggressive and have various sexual partners is in itself paradoxical as one would then question where the men are expected to get their sexual partners from. These social constructions of femininity and masculinity with regard to sexuality present contradictory expectations that could be argued to contribute towards an implicit sanctioning of sexual violence (men can/should have sex at will and women should not). This attitude was further seen in some adolescent males in the groups we talked to, who for instance felt that they can '*sometimes use force*' if girl's say no to their sexual advances.

The expectation of a woman's subservience in male-female relationships, expressed in the debates on 'rape in relationships' (section 4.3) may effectively deny women control of their own sexuality. Ironically, even with limited control, women are expected to be able to say no to men's advances (whether platonic or sexual) as expressed in suggestions that women/girls should not be engaged in relationships before marriage. Women seem to have limited decision-making power in sexual relations and control of their bodily integrity in relationships seems to be bestowed on their male partners. To what extent this is true was not established in this study. Women's agency in sexual relations as well as response to violence was neither explored and to a large extent not reflected in discussions. While this is a shortcoming of this study, possibly due to the formal nature of study (as discussed above), further consideration for promoting agency is discussed below.

Adolescent females seem to express women's agency more than adult females. In section 4.3, group discussions reflect adolescent's point of view that girls' have a choice in relationships and whom they choose to see. This sense of empowerment is not highlighted elsewhere in group discussions. Arising questions may revolve around whether women really have no agency and are completely powerless?? Highlighted are passive tactics to evade sexual violence as reflected in participants' experiences, such as, feigning sickness (section 4.3) or not visiting men's houses alone. These actions do show resistance and possibly present resilience of women and girls towards sexual violence. Sexual violence prevention interventions need to build on this initial resistance. The gendered nature of socialization that dictates women's position as passive in sexual relations is central to the recognition and application of agency. Consideration for building on traditional actions and experiences that promote agency (such as seen with the '*Kungwes*' – section 6.3) could be integral in future interventions on HIV and violence.

In reference to the South African experience, while advocacy and government will has gone a long way in infrastructure, policy and financial commitments for addressing rape, social values that perpetuate rape still remain strong (table 4.6). This reflects challenges of changing society attitudes, thus prompting the question, how do we promote change?? There are emerging implications for use of Moser's (1993) practical needs vs strategic interests framework (section 3.5). Taking on a practical needs approach to services provision in medical and legal response will support rehabilitation and ensure basic and effective functioning and survival for survivors of sexual violence. A strategic gender interests approach would suffice to promote agency, while working towards changing values that promote sexual violence. Possibly more enquiry is needed to establish existing agency and ways to promote further agency on sexual violence. An opportunity for further research into the ways in which different people at personal and community levels challenge gender power relations is presented.

Perceptions of femininity and masculinity: Partners, family members, close friends and associates often blame survivors of sexual violence. Discussions reflect women's perceived responsibility in preventing rape particularly in relationships, though they are seen to have limited power in setting or negotiating conditions in which the relationships exist (section 4.3). Emerging from these debates and discussions is the perceived lack of responsibility for control of sexual desire by perpetrators that may be construed to justify violence. Sexual violence seems to be sanctioned and as noted by Jewkes (2002b) has cultural approval, with implied responsibility on women to fulfil men's sexual desires (Table 4.8). Women's sexuality appears from the findings to be closely tied to male expectations especially in marital relations as observed in some group discussions (section 4.3). This can be linked to the dominant ideology that fulfilment of sexual desire is essential to men's nature seen in Gupta et. al (2002).

On the same note are notions of masculinity that emphasize domination over women as seen in discussions on dowry, for instance and the value (or lack of) placed on women being further emphasized here. There seems to be recognition of male ownership rights over women on this basis (section 4.3). The claims to sex rights that were presented predominantly in male groups by virtue of having paid dowry have been discussed in Kenyan literature by authors such as Nyamu and Gathii (2000:54) who note that, "*payment of dowry reinforces this attitude, further devalues the dignity of women and makes it easier for coercive or violent conduct against women to be tolerated*".

Male rape is hardly acknowledged and is seen to be '*more shameful*' than female rape (section 4.5). This is evidenced in public reaction to rape of boys from example given. Studies on masculinity have highlighted men's perceptions as being powerful and in control of sexual relationships (Kristner, 2003). Sexual violence, while demonstrating power on the part of the survivor, results in feelings of powerlessness and shame by the survivor. Male rape takes away this perceived control and thus challenges gendered identities on which social norms and values are based. As a result, male rape will be kept secret with more stigma experienced by the survivor. As seen in literature (table 3.2) the risk of HIV transmission following insertive anal sex is higher compared to other methods of transmission therefore increasing male vulnerability to HIV in the context of sexual violence. Thus interventions must take into consideration constructions of masculinity in addressing sexual violence.

Alongside construction of sexuality for men, are societal expectations of women. Group discussions seem to reflect women's value to be based on what could be referred to as '*sexual uprightness*'. Shame and stigma experienced as a consequence of rape could be placed squarely within these expectations. Again, the femininity requirement that women be ignorant or not engaged in sexual relations seems to dictate society's reactions to women who are violated especially by their partners. From discussions, shame seems to be associated with a loss in value reflected in statements implying that women '*will loose market*' (section 4.5). The inherent suggestion here is that of women being in a market situation where they are trying to sell themselves off to men and reflects a placement of women in categories of '*good*' and '*spoilt*' where the '*spoilt*' category may be unable to enjoy the status quo of those considered '*good*' in social value.

Contemporary society vs 'African culture': Women's placement in a '*market*' situation is seen in discussions on reasons for not reporting rape. This could arguably be linked to the portrayal of women by the media. The media has become a major agent of socialization and has gained a significant role in the definition of standards and entrenchment of values and ideals today. It has been and is increasingly using women and their bodies for advertising. According to Gita Sen (1997), the objectification of women as purely sexual creatures is constantly reinforced with limited cognisance given to women's intellectual and emotional worth. Sexual arousal for men seems to be a foundation on which commerce is enhanced, promoted and commodities sold. The value therefore

that society attributes to the woman and her body (as embodied in the media) can be linked to tolerance of rape at personal levels and by society and at macro-levels, the limited action towards sexual violence. Subsequently, there is an entrenched desire by women to keep sexual violence a secret, to avoid shame, victimization or falling into the 'spoilt' category by the person who has been violated.

In the discussions pre-marital sex is often reflected as '*not-African*' (sections 4.4, 4.5). This is one of the explanations given as to why women will be shamed when they have been raped. At this point it could be pointed out that the concept of an '*African culture*' is in itself non-existent (hence the quotes used for the term). It is based on an assumption of ethnic homogeneity across Africa while in reality there are hundreds of different ethnicities with different cultural orientations and practises. With specific regard to sexuality for instance, while girls' virginity at marriage may have been emphasized and valued by some communities across Africa such as the Xhosa in South Africa (Kistner, 2003) or the Kalenjin in Kenya, this was not consistent as shown by the Akamba in Kenya who required that a woman be sexually experienced before marriage and sex education and practise was part of initiation for girls.

Reference to '*African culture*' in the discussions therefore, may on the one hand signify a shift from community specific norms and values towards more ethnic-shared values across Kenya. On the other hand, it could reflect an emerging vacuum in social norms in the context of ethnic, economic, religious and political diversities where people are not sure what culture they abide. While specific cultural practises and traditions can be positively used to enhance women's agency around sexual violence (or deconstruct forms of masculinity that identify with domination and violence), the generic application of the term 'culture' has been used to perpetuate stigma and discrimination around sexual violence. As Kistner notes, "*talk of 'culture' has often been used to justify institutions and practises that undermine women's autonomy*" (2003:15).

Based on the controversy the sense of '*African*' traditional dress (or again, the lack of it) raises in discussions (section 4.4), it is fundamental to understand the place of dress in emerging contemporary gender roles and responsibilities for women. Ways of dress were and remain a form of identity for communities. In many traditional Kenyan societies, specific dress forms were reserved for different occasions and age groups based on dictates of the society. Tensions arising over women's dress may be associated with part resistance to perceived increase in self-expression by women. In less egalitarian societies, women's space in time, movement and expression (including mode of dress) could be seen as subject to male control and authority in varying degrees that are culture specific. For instance, in our discussions, blame was placed on women raped due to walking after dark since they 'should not' have been walking at this time. Despite the fact that there is really nothing 'African' about current modes of dress, women are seen to have a responsibility to dress in a certain way (in this case, dependent on emerging social norms), to avoid being violated, even when the sense of decency in ways of dressing is seen again in the discussions to be very relative to place.

A key issue arising however is the shift of responsibility of sexual violation from the perpetrator to the survivor. The justification for rape reflected in discussions is therefore based on gender stereotypes and women's placement in sexual and gender power relations. Interestingly, while it was largely felt that there was no rape in marriage, in subsequent discussions, the terms 'wife' and 'husband' were constantly referred to in the context of rape in some groups. A general contrast is seen in views presented by male groups that edge towards tolerance and justification for rape, though there were some diverse and strong feelings that rape is not justifiable in whatever circumstance (section 4.4). Women groups lean towards feeling that rape cannot be justified by whatever means, with calls for action towards addressing rape. However, within women groups are

some women who feel that rape is justifiable in certain circumstances and this is more evident in women and girls group discussions from Malindi and from the rural part of Thika (table 4.8).

Sexual violence seems to be more sanctioned among males (both adults and adolescent) and particularly within pre-existing sexual relations. The construction of gender in ways that perpetuate gender based sexual violence is not constrained to men/boys only. Women/ girls participate in practises and attitudes that serve to fulfil norms of femininity and masculinity that subscribe to violence.

Discussions in this section highlight the interactions between gender inequities and resultant power relations and how these influence vulnerability to sexual violence and thus HIV. Gendered relations therefore continue to influence and shape risk, vulnerability and resilience to sexual violence. At the personal level, are issues around reporting violence as a crime (since it is not necessarily viewed as such); seeking help and support to deal with the effects, disclosing sexual violence to a significant other. At a societal level, there are issues around dealing with the institutions that are mandated to protect Kenyans, and provide medico-legal services including the criminal justice system.

The following section analyses responses of social, legal and medical institutions to sexual violence within this context of gender power relations.

6.5 Gender power relations: Social, legal and medical response to violence

Women's perceived responsibility in 'avoiding rape' is reflected again in discussions of time and places where women should or should not go (section 4.4). While it only makes sense to employ standard self-protecting mechanisms such as being careful where one walks and at what time, suggestions that point at justification for rape in these circumstances once again highlight gender inequities in the control of individual space. The question of time and place within which women are supposed to operate (in order to protect themselves from attack and violation) indicates inherent attitudes of restriction in place and time of movement imposed on women by society. These restrictions are not written or verbal and have no legal standing, but are assumed. Actions out of these boundaries put the woman to blame for outcomes experienced. Women in particular have and continue to find it difficult to convince the police, health care service providers and other institutional agencies to whom they report, expect and are entitled to find help when raped. The onus is on the woman to prove that they have been raped making it the only crime in the statute book where the 'victim' is also on trial and is required to have resisted attack to prove it.

Legally, there are provisions that serve to protect the rights of individuals (both men and women) in Kenya. However, social considerations on sexuality hold different views and are more often than not the basis of judgment and action in everyday life. Operations at the household level, communal expectations and institutional laws and regulations have their foundation in social norms and values. It therefore becomes important to distinguish between rights vested in individuals and those vested in communities as dictated by law on the one hand and society on the other, as they clearly influence and shape the vulnerability of women and men to sexual violence. The provision of post-rape services within the prevention to care continuum must extend beyond conception of sexual violence as that perpetrated by a stranger to acknowledging and dealing with broader social aspects of coerced and forced sex from family, partners and acquaintances.

6.6 Multi-disciplinary approaches:

National level collaboration between stakeholders providing services for sexual violence in Kenya has only just began through the 'medico-legal network'. The government forms a major stakeholder yet is un-represented within the network and similar groups. Sexual violence is a crime and a health

issue placing it centrally in the criminal justice system and health care systems. Its effects, which extend to the family and community in general necessitates the involvement of social service providers. Collaboration and coordination agencies providing these services are therefore fundamental to addressing sexual violence. Government involvement and political will is critical in development of and action on gender-based violence as is seen from the South African experience (table 4.6). Poor enforcement of legislation, lack of national policies from the Ministries of Health and Justice and Constitutional Affairs in Kenya perpetuate sexual violence and hinder management of survivors. The civil society also, has a role to play in advocacy of government and education, information and awareness raising among communities. Again the importance of local interpretations of sexual violence is seen here. Post-rape care and service delivery by the civil service will need to be coordinated with collaboration and strong linkages with government who in turn need to provide a regulatory framework and an enabling environment within which to operate.

At the district level, the health sector often works in isolation of other related sectors such as education and security. There is little linkage between the district hospital and say, the police, although police bring survivors for examination and at the same time pick results of forensic analysis from the hospital. In district decision-making levels, cross-sector linkages are also lacking. District Health Management Teams who are the focal point for district health services management, identifying health priorities and making expenditure plans work in isolation of other committees that run services in the district. For instance the District Medical Officer of Health may be called to District security meetings to report on assault and pathology findings but does not sit on these meetings. Experience from the Western Cape in South Africa in the implementation of the “Hands-off-our-children” campaign, highlights the possibilities for partnerships and multi-disciplinary approaches towards dealing with sexual violence (table 5.4).

Establishment of multi-disciplinary approaches to addressing sexual violence requires collaboration between the government, civil society and private sector stakeholders across the tiers of service provision – the national, provincial and district levels. Referral mechanisms require to be strengthened accompanied by clarity of roles and responsibilities of the involved agencies thus addressing concerns regarding poor uncoordinated service provision at all levels.

6.7 Health care perspectives

Various models of service provision aimed at enhancing efficiency, reducing secondary trauma of survivors and cutting the bureaucracy have been advanced. ‘One-stop rape crisis facilities’ where counselling, clinical, social and police services are available in one place were seen to be increasingly common in the Western Cape (table 5.5). Key challenges arising on establishment of one-stop rape crisis facilities are those of sustainability and affordability. Establishing, equipping and maintaining such centres would require continuous financial commitments from stakeholders (government and civil society) outside of the existing budgets. Further these places would offer services running parallel to what districts/government primary health care institutions offer. While this would be the ideal situation, it may not be possible due to resource constraints involved. Integration of post-rape services into already existing primary health care offers possibilities of affordable, accessible and comprehensive services for all Kenyans.

Sexual violence: an emergency?? The integration of sexual violence services in trauma or casualty units in health institutions often relegates sexual violence to the periphery (section 5.3). The physically visible life and death situations in these units are often seen as greater emergencies. Required would be logistical and operational mechanisms that give due priority to rape survivors. This would mean addressing issues of; long queues that sexual violence survivors have to undertake in hospitals, documentation and attitude amongst health care workers and police towards survivors.

Clients often queue for long in hospitals (section 5.3) thus are unable to get immediate doses of PEP and emergency contraception required. The urgency required in taking the first dose of PEP has implications for referral systems; should survivors of sexual violence be referred to the hospitals or to police stations first? This dilemma was reflected in questions raised by focus group participants (section 4.6). Traditionally, a report is made to the police who then provide a P3 form that the survivor carries with them to the hospital for the doctor to fill. However, time between exposure and the first dose of PEP clearly has implications for this procedure. Police therefore need information and awareness raising on the importance of immediate reference to hospital. Documentation at the hospital level could be improved to ensure that examination results of clients who visit the hospital first are captured in P3 forms when they are available.

Information/data: Evidence from literature (section 3.8) indicates high health costs at individual, community and macro economic levels from sexual violence. Health records at district hospitals do not reflect sexual violence (as highlighted in the study limitations, section 2.8;1) hence it is not captured at national levels. It is therefore difficult to quantify the costs of violence on Kenya and move towards influencing advocacy, information and awareness. The lack of data corroborates literature that shows scarcity of data on sexual violence (Randal 1997; section 3.3). Planning for health and for advocacy in prevention, care and rehabilitation of survivors is therefore hindered. Possibilities for institutionalising collection of data on sexual violence from health care institutions could be explored within a framework of national guidelines.

Medical evidence: is fundamental to investigation and prosecution. Forensic medical examination should essentially include a physical examination covering the assessment of injuries (if any), collection of evidence from the whole person – clothes, hair, all body parts and careful and internal examination of the perineum and a careful documentation of the same. Sample collection from all body parts including the mouth and genitalia for testing in the laboratories is essential. However, collection of all these samples only makes sense if there are facilities and systems for analysis. Further, taking these samples is a traumatic experience for the survivor as noted by a clinical officer (section 5.3; examination processes). Clearly, there are ethical and moral concerns of evidence collection given the absence of a functional forensic medicine system in Kenya.

Collection and analysis of forensic evidence presents challenges to district systems that are fraught with difficulties of limited capacities of health care workers in information and skills to undertake forensic medical examination and to analyse samples collected. In Kenya, capacity for DNA (deoxyribonucleic) testing is found in the Government chemist at the national level. Ideally, evidence will pass on from the medical officer to the police officer, to the Government Chemist with results following a similar feedback mechanism. DNA testing may be the most ideal way to undertake analysis and determine source of evidence. However, it is too costly to apply as a standard for the resource poor setting in Kenya. Districts can therefore only undertake a limited number of tests. Poor forensic examination due to lack of capacities translates directly to limited or poor evidence. Compounded by poorly handled investigations as a result of institutional disregard for rape and police/community attitudes (section 4.5), this translates into the dismal prosecution rates evidenced.

Chain of custody of evidence: Links between medical examination processes to the legal system requires careful documentation. Of significance here is that, maintaining the ‘chain of custody of evidence’ (a paper trail where the movement of evidence is traceable through the different persons in the chain of sample collection, analysis, investigation and litigation) is probably the most critical aspect of the interface between medical and legal agencies. Lack of records in the hospital that reflect handover of specimen from the hospital to the police present a major gap for litigation. Given the neglect or/and virtual collapse of a system ‘the chain of custody of evidence’, it is therefore not surprising that little attention is given to examination and documentation of sexual

assault and subsequently handling and management of evidence by medical, laboratory and officers of the criminal justice system. A chain of evidence of custody) is essential and must be considered as part of processes of service provision in health care facilities where forensic examination is undertaken. The lack of a forensic medicine system in Kenya is compounded by legal requirements that only doctors can give evidence in a setting where there is a limited number of doctors. Shortcomings noted circumstances where the doctor filling in the P3 form is not the examining officer (section 5.3; medical evidence) could be overcome through change of legislation. A potential area for advocacy aimed at service delivery improvement would be around changing the law so that other health care workers such as clinical officers can act as informed witnesses in court.

Costs: Charges found in the district hospitals were seen to hamper treatment seeking after rape. Rape survivors are required to buy cards on which their medical information is registered. Currently laboratory tests taken in these hospitals require that clients pay user fees. This would translate to the need for rape survivors to pay for costs in HIV testing and any baseline blood tests to be taken before the administration of PEP. There is a definite need for policy intervention to ensure that in public institutions services are availed free of charge.

It is clear that DNA testing may be too costly (14,000 Ksh per run = US\$186)¹⁷ to apply as standard procedure for rape. In a country where a 56% of Kenyans live below the poverty line (1US\$ per day) (GoK 2002d), the charges to do DNA testing are astronomical. However, in the event of other criminal investigations such as robbery, the government pays for DNA tests that may be required. However, the same standards do not apply for rape even though rape is a crime against the state. Clearly there are discrepancies in policy regarding the use of DNA testing reflecting the importance (or lack of) attached to addressing sexual violence in Kenya. Emerging concerns revolve around the possibility that use of DNA may make this a standard requirement for conviction that would be unaffordable. Further are concerns on the possibility of conviction even after such expenses.

Post Exposure Prophylaxis (PEP): In addressing clinical management of sexual violence, special attention must be given to HIV. Growing discourse on violence and HIV highlights biological, technical and ethical considerations for PEP therapy. Biological considerations debate the potential efficacy of PEP for sexual exposure (Kim, 2000). This includes an assessment of the biological and disease related factors that influence vulnerability to HIV/AIDS infection: the probability that the perpetrator is infected; the clinical status of assailant infection and the type of exposure.

Technical considerations raise a myriad of questions on policy, systems and mechanisms for ARV administration and management.

- Efforts to develop and put in place ARV policies and guidelines need to incorporate not only mainstream ARV provision (for people living with HIV) but other circumstances of ARV use, in this case, PEP for sexual exposures.
- The existing policy vacuum on post-rape management poses challenges for potential abuse of PEP therapy (in unguided prescription, poor administration and ineffective client management).

The potential impact on ARV therapy in Kenya with regard to costs of PEP for sexual exposure is uncertain given the lack of data. Current reports cannot be used conclusively to make plans due to uncertainty surrounding actual occurrence or prevalence of rape in Kenya (section 3.7). Knowledge and availability of PEP therapy could possibly influence reporting patterns as it provides a solution to the fear and anxiety over HIV experienced by survivors of sexual violence (section 3.8). The lack of capacities for ARV administration among health care workers raises concerns regarding the potential impact of ARV and specifically PEP therapy. The cost of PEP has implications for

¹⁷ I have in this case used the exchange rate of 75ksh. to 1 US\$ and this information was provided at the Naro Moru

sustainability; will the government make financial commitments towards development of capacity (human resource and institutional) in primary health care institutions and towards continuous supply of PEP for sexual exposure?? While these are very pertinent questions, more information on the processes of development and establishment of PEP provision mechanisms is required for any policy decisions to be made.

Ethical considerations, suggest a need to provide some space for a survivor to recollect him or herself and think through the implications of a HIV test that may turn out to be already positive. Practice in South Africa suggests that it is possible to provide a start dose of PEP accompanied by counselling and an HIV test can be undertaken up to 3 days thereafter. If the HIV result is positive, then no more PEP will be administered and if it negative, then PEP should be continued.

Challenges presented by drug adherence (section 3.8.1) due to toxicity and immediate concerns on efficacy of PEP for sexual exposures have been partly addressed through studies in South Africa (Kistner 2003). This review of PEP provision for rape in South Africa, provides an account of some factors for consideration in enhancing drug compliance; support systems such as counselling services, simplified information, assessment of self-perceived risk of HIV infection. Clearly, any plans for the provision of post-rape services including PEP in Kenya, must take into account these factors.

Counselling services: The gap in counselling in Kenya starts at policy levels where counselling is not a recognized profession either in its' own right or as part of health care services within the establishment of the civil service. Participants from group discussions and key informants noted the essential nature of counselling as well as the lack of services. The use of VCT counselling services, while providing backstopping for survivors of sexual violence, is not comprehensive and does not address critical issues of trauma, post rape trauma syndrome for the survivor. Literature indicates long-term effects that affect not only the survivor but the family as well that must be taken into account thus necessitating counselling services not only for the survivor but also for their family members and particularly partners.

In the Kenyan context, HIV counselling is primarily offered through an established and coordinated VCT service provision infrastructure. It was clear from findings that VCT centres in primary health care are increasingly playing a role in post-rape counselling particularly with the anxiety over HIV infection. The broader policy environment on HIV and VCT in Kenya is substantially different from that of sexual violence in that there are systems and structures in place, supported by a functional policy framework. The Sector Wide Approach (SWAp)¹⁸, though said to be at the beginning of the process continuum in Kenya has been essential in planning, implementation, monitoring and evaluation of HIV/AIDS interventions (Kilonzo et.al 2002). All interventions particularly with regard to VCT are undertaken within a common framework as approved and guided by the Ministry of Health (MoH). Coordination and regulation of Voluntary Counselling and Testing (VCT) service provision by the National AIDS and STIs Control Programme ensures adherence to set standards. The role of NGOs in implementation within this framework reflects a symbiotic relationship in service provision that is evidenced in the development of VCT services in Kenya. Development of these mutual relations between stakeholders has been a learning process from which establishment of post-rape services can learn from.

The use of PEP brings along new challenges for survivors. It is a requirement that the HIV status of the survivor be known for PEP administration. Having to deal with one's own status at the time of trauma in a situation where one has not had to think through this presents implications for the

¹⁸ The Sector Wide Approach is an increasingly common approach to aid where donors pool money into sectors and the

survivors. Literature clearly highlights inter-linkages between HIV status and violence (Maman 2001; section 3.7) that need to be explored in the context of PEP provision. Wider social implications of HIV testing including marital status and family interaction are essential. Placing all these concerns on a survivor requires adequate post-rape counselling skill. Low drug adherence rates are of concern for PEP prescription (section 3.9.1). Counselling including drug adherence counselling would provide the support needed by survivors to go through prescribed regimens. Kistner (2003) identifies counselling support as key to drug compliance strategies.

6.8 Legal perspectives

Findings on services and facilities available for post-rape services reflect a gaps in legislation and policy on sexual violence. Enforcement of existing legislation is poor, litigation processes are hampered by attitudes that are based on social norms and values that were seen to hinge on and reflect community gender power relations (section 6.4). Clearly, there is need for advocacy for improved legislation, and intervention support aimed at change of values and attitudes within the criminal justice system (police, magistrates).

While these highlights were identified and are key to addressing sexual violence, they are outside the mandate of this study and therefore are not discussed exhaustively in this report.

6.9 Conclusion to the discussions

To bring together the implications of gendered nature of our society, on social norms and values, it is pertinent to draw out inherent inequities in gender power relations from the above discussions that could be seen to influence vulnerability to increased violence and HIV. These are reflected in:

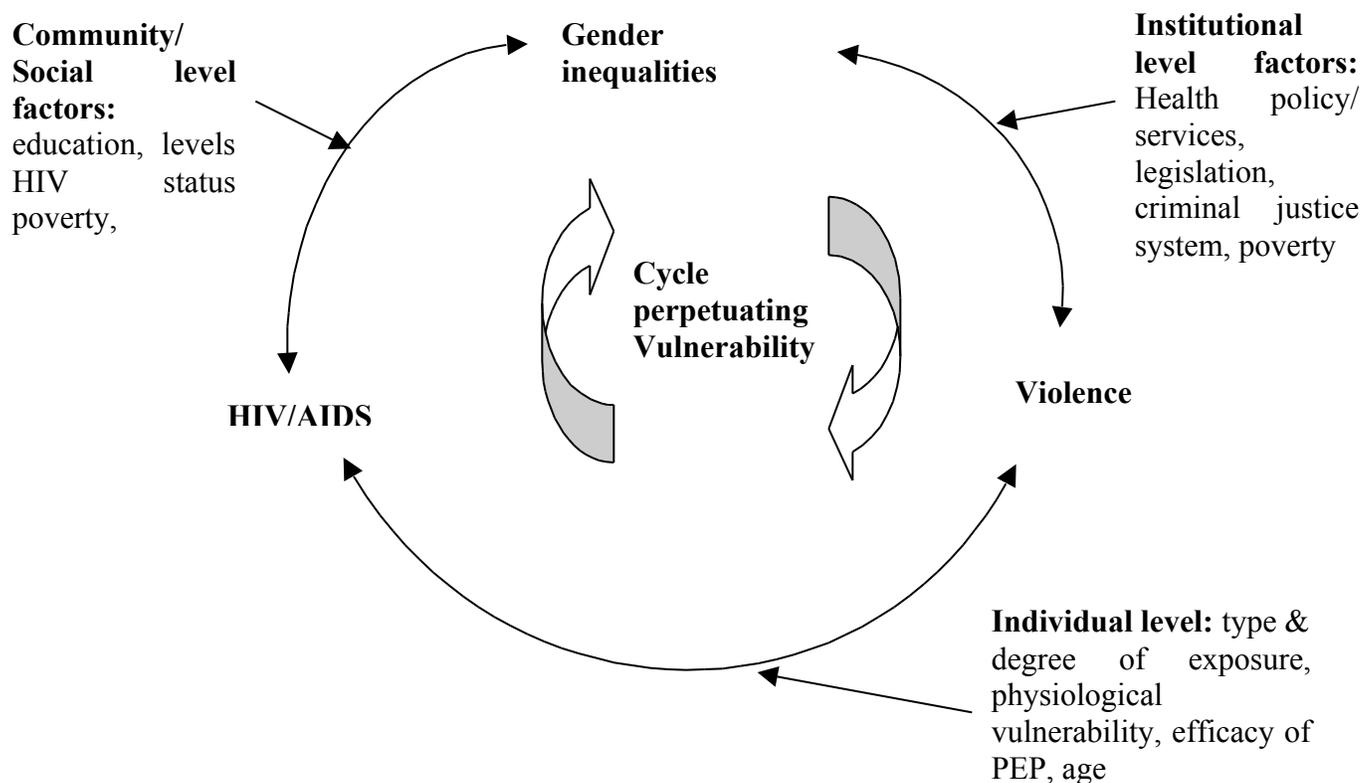
- A more closed sexual culture for women than for men that has implications for access to, dissemination and use of sex related information.
- An implicit assumption to male rights to sex that makes it difficult to understand, accept and act on sexual violence within the context of marital relations, or even close social relations in such cases as incest and serves to increase women's vulnerability to increased violence.
- A perpetuation of identities of masculinity and femininity that promote violence and the application of 'African culture' to undermine household, community and state efforts towards dealing with sexual violence
- Fear of challenging violence at a personal level can be closely associated with the fear to report sexual violence, even that which happens outside of close relationships due to shame and stigma associated with sexual violence and placement of blame on the survivor.
- The rationale and justification advanced for rape during group discussions only reinforces the fear to challenge violence and subsequently entrenches unequal gender relations. The dominant ideals of masculinity and femininity and their perpetuation through socialization and social sanctioning of violence expressed above exacerbates violence, resulting in an acceptance of norms that promote the unequal status of women and men. These unequal gender relations and power imbalances determine women's vulnerability to violence and subsequently to HIV and AIDS.

Dealing with the gender related practical needs seem to be the priority with little/no relevance to strategic needs (refer to definitions of key terms in the report – section 1.4) where sexual violence is concerned in Kenya. This is evidenced by the focus on immediate physical injuries on women with limited attention to on-going support and rehabilitation that would essentially entail empowerment processes. Understanding the construction and perpetuation of masculinities and femininity in Kenya would provide a good basis on which to lay prevention interventions, existing difficulties include the diverse ethnic systems in Kenya and the dynamic nature of gender relations in contemporary society. Approaches that challenge dominant ideologies and value systems must be

supported and advocacy sustained. Interventions need to be based on sound research, including social and gender analysis and encompass multidisciplinary approaches.

A theoretical approach to analysing the links between gender inequalities, violence and HIV/AIDS could be explored as the conceptual basis on which the complexity of interactions between individual, communal and institutional factors influencing sexual violence is framed. Such an exploration would provide an opportunity to identify and strategically address factors influencing vulnerability to violence and HIV that seems to occur in a cycle. While considering each of these levels in turn would enhance their analysis, it falsely separates complex and inter-related factors. This complexity can be conceptualised with reference to the ‘HIV and Violence: gender vulnerability chart’ (Fig. 2.2).

Figure 6.1 Conceptualising vulnerability to violence and HIV



From policy to action: Translation of instruments into laws and their subsequent enforcement therefore requires a social transformation towards understanding and accepting the necessity of universalised responsibility of individuals, communities and states of equality and human rights for all. The challenge amid these commitments is to create a link between international declarations, national broader policies and implementation levels by service providers that are grounded on local interpretations of sexuality and sexual violence. The lack and inadequacy of post rape care services presents a challenge to addressing sexual violence but can perhaps be viewed as the greatest opportunity for the establishment of appropriate systems, procedures and mechanisms for addressing sexual violence.

The following chapter (7) draws on the discussions from this section and points out key implications for post rape services provision in Kenya. Recommendations that provide the basis of a strategy for provision of post rape services in Kenya are provided.

CHAPTER IMPLICATIONS AND RECOMMENDATIONS FOR POST-RAPE SERVICES IN KENYA

This chapter analyses the implications for provision of post-rape services in Kenya in consideration of the gaps, challenges and opportunities emerging from this study. It starts with a summary text boxes for each of the critical issues emerging that are discussed in following subsection: gender power relations and social norms, implications for health care services provision, for legislation, policy, advocacy and stakeholder collaboration and research. Highlighted are broad issues that have implications for post-rape services for Kenya. Specific study recommendations (adopted by Liverpool VCT and care Kenya) that capture the fundamental aspects raised in this study are provided at the end.

7.1 Summary of study considerations and recommendations

Emerging from this study are general implications for post-rape services delivery in Kenya.

- Awareness, information and education interventions informed by social considerations
- Considerations made for strategic gender needs when addressing practical needs of sexual violence survivors
- Infrastructure for service delivery to be put in place
- Policy and legislation on sexual violence strengthened
- Further research on sexual violence: data, implications for prevention, care and rehabilitation
- Multi-sectoral response prioritized

Study recommendation:

Implementation of comprehensive post-rape services in 3 VCT sites located in primary health care institutions as a pilot intervention study to inform scale-up in Kenya

7.2 Examining social norms and gender power relations

Gender power relations were seen to influence provision of health care services. While provision of good services goes a long way in dealing with the survivors mental, psychological and physical self, the social dimensions of sexual violence that are fundamental and shape vulnerability to rape and subsequently HIV and AIDS must be addressed from a health perspective. The challenge is on the health care services providers to integrate the provision of practical gender needs (medical care) with support of strategic interests (information, awareness creation and referral services provision) when dealing with survivors. This may impact positively on reducing stigma and enhancing support of rape survivors which in turn increases reporting and visibility of rape as a primary problem.

7.3 Policy, advocacy and networking

Collaboration and networking between stakeholders (donors, government, civil society) provides the best option for planning and delivery of services. As emphasized by Moreno (2002:138), “*the need for a well coordinated multi-sectoral response to violence against women is obvious*”. A network of organizations and individuals (champions of change) is necessary to act as a key driving force towards implementation. The Government is a key player for the success of any plans and interventions. Stakeholder collaboration forms a basis of the development of a comprehensive implementation strategy.

Legislation on sexual violence in Kenya will need review. An operational policy framework would need to be institutionalised with mechanisms to effect implementation of service delivery within national standards being put in place.

Making rape a public issue/advocacy Advocacy needs to be grounded on the strength of different stakeholders with a common purpose and common goal. Evidence based advocacy strategies are more likely to influence legislation and policy. Research therefore begins to play a critical role in supporting services for sexual violence. Action oriented research can serve to challenge existing norms, raise awareness and public debate and more so provide evidence on which advocates can base advocacy.

7.4 Health care services provision

Health care systems and processes in district hospitals in Kenya: Infrastructure for service provision would include the development and institutionalisation of policy, development of standards and protocols. Coordination, regulation and supervision of services would need to be put in place. Consistent and systematic monitoring and evaluation will strengthen service provision.

Capacities in addressing rape/sexual assault include training health care service providers – counsellor, medical officers, nurses, clinicians as well as laboratory personnel. Areas that need the development of capacity include forensic medical examination, sample collections, handling and management, sample analysis, clinical management of rape, ARV action and PEP therapy and documentation. Capacity needs to be built within the criminal justice system including with the police, judges, magistrates etc. While training and capacity building may have noble objectives a limitation has been the often use of training as an isolated intervention with little follow up and it becomes an end rather than a means (Moreno, 2002). Training will need to address technical content rather than the experiences, attitudes and values of service providers.

Post exposure prophylaxis: Essential to any attempts for service provision are plans for sustainability, which can only be ensured through PEP provision by the Ministry of health. International concerns on efficacy and cost-effectiveness of this therapy can be addressed through close monitoring and documentation of service provision on a pilot basis.

Broader structural dimensions of equity of access of PEP call for policy consideration. Ethical issues surrounding PEP provision such as dealing with one's HIV status at this time of trauma and wider social implications HIV testing on – marital status, family structure have a bearing in PEP provision strategies. Counselling is therefore key to support dealing with trauma and backstop drug adherence concerns.

Counselling: Obviously counselling has a role in its own right and can therefore not be subsumed in larger bio-medical care service provision. This necessitates the establishment and recognition of counselling in health care services in Kenya. This calls for:

- The establishment of counselling within the establishment of civil service in Kenya
- The institutionalisation of counselling in health care services provision in Kenya
- Development of technical capacities for counselling in the context of sexual violence
- Change of attitudes amongst health care workers

Voluntary Counselling and Testing service provision: The availability of established infrastructure in district hospitals with VCT services offers a unique opportunity for post rape care services in Kenya. VCT services located in primary health institutions offer existing expertise in rapid testing with pre and post-test counselling for HIV that is essential for PEP administration. The confidential and supportive environment offered in VCT centres is so far not available in other health care

facilities. Counsellor support supervision structures and referral mechanisms for other services have been developed within VCT. These could potentially be extended for rape trauma counsellors and trauma services and this would serve to increase the sustainability of post-rape services in Kenya. The expected roll-out of VCT in Kenya, further provides a platform on which post-rape services can be scaled up in post-rape services.

7.5 Research:

Gaps in research on sexual violence have been noted. The implementation of post-rape services in Kenya as a pilot intervention research would begin to address some of the gaps identified and provide opportunities to begin to answer existing research questions on sexual violence, HIV, PEP and VCT.

- The lack of prevalence and incidence data on rape as most data is available from places where people reporting have been exposed to violence. There is need to gather data from a random population. VCT site in Kenya that see drop-in clients are a unique opportunity where screening of clients for sexual violence can be done to give a better indicator for Kenya.
- Most models on post-rape service provision are based on developed countries that are significantly diverse in socio-cultural, political and economic aspects of life. An intervention study for provision of post-rape services would identify options and what is feasible in Kenya, given the current systems and structures in primary health care institutions that can then be scaled up in the future.
- Technical and policy questions on PEP provision could be explored in the context of an intervention study. Questions that could be answered include:
 - What percentage of those who present for post rape care are already HIV positive?
 - How are they able to cope with knowing their HIV status and this time and what is the best strategy for support?
 - What are the existing PEP adherence levels and PEP effectiveness?
 - What is the impact of PEP provision on other services and sectors relating to post-rape care?
 - What is the cost-effectiveness of PEP provision? (as part of comprehensive post-rape care services and on it's own) What are the risks/benefits and effectiveness of other components of post-rape care explored separately?
- Multi-disciplinary approaches towards gender based sexual violence in the prevention to care and rehabilitation continuum need development for the Kenyan context. Monitoring and evaluating these approaches will identify what is effective and sustainable and can be borrowed for other cross-sectoral gender related issues that need advocacy.

7.2 Specific study recommendations

The study findings and literature review all highlight critical gaps in the provision of post-rape services in policy and practical responses to gender based violence. There is need to strengthen links between HIV prevention and care services in consideration of the gender inequities existing in Kenya. This study therefore recommends the implementation of a strategy for the provision of comprehensive post-rape services in 3 VCT sites located in primary health care institutions as a **pilot intervention study**. The study will identify what is feasible and realistic in different Kenyan contexts, the benefits and effectiveness of different elements of a comprehensive approach and will explore the added benefits of a comprehensive intervention. It will link policy responses to practical service provision to inform scale-up in Kenya.

Overall policy considerations recommended:

- Policy development and institutionalisation by the Ministry of Health specifically through Division of reproductive health: standardized operational guidelines and procedures

Operational and logistical procedures for providing comprehensive quality services:

- Establishment of operational systems and mechanisms for post rape services provision of: clinical and physical care, PEP, STI and pregnancy prophylaxis & any other management
- Counselling capacities and services for trauma, HIV testing during trauma, disclosure, on-going support for survivor and family, drug adherence
- Support supervision structures for counsellors to develop counsellor capacities, reduce burnout and ensure quality counselling

Training and building capacities:

- Training and capacity building processes (education, information seminars etc) for medical and clinical officers, nurses at casualty and outpatient departments on: Forensic examination, sample collection, handling and analysis; PEP administration and management

Recognition and support by the District Health Management Teams is core to establishment of effective services

Multi-disciplinary approaches:

- The '*medico-legal network for gender based violence*' be used as a vehicle for advocacy on legislation and policy for GBV in Kenya.
- District level stakeholder forums be promoted in parallel to the implementation process with a focus on strengthening capacity to respond to sexual violence.

Monitoring and evaluation system be set up for the implementation process. It should include collection of relevant data.

- Referral systems to the local police station and legal protection and support services where possible.

Partnership and collaboration with the Ministry of Health through the Division of Reproductive Health is fundamental to enhancing accessibility and availability of post-rape services in Kenya.

The above specific study discussions have been used to develop a strategy for post-rape services provision that Liverpool VCT and Care Kenya (LVCT) has adopted and is taking forward in an operational implementation phase.

BIBLIOGRAPHY

- ___ 2002, *sexual assault in adults*, in Drug and Therapeutics Bulletin Vol 40 No. 1 January 2002
- Amnesty International, 2002, *The optional protocol*, AI-Index: IOR 51/008/2002
- Amnesty International 2002, *Kenya, Rape – the invisible crime*, AI-Index: AFR 32/001/2002
- Bamberger J, Katz M, et.al. 1999, *Post Exposure prophylaxis for Human Immunodeficiency virus (HIV) infection following sexual assault*, The American Journal of Medicine, Vol106;323-6
- Burton B, Duvvury N, & Varia N, 2000, *Justice, Change and Human Rights: International Research and Responses to Domestic Violence*, Centre for Research on Women/Centre for Development and Population activities, USAID
- Caesar M. 2001 *The interrelationship between HIV,ADIS and Violence against Women*, in AFLA Quarterly, January-March 2001 – HIV/AIDS and Human Rights
- Campbell J, Nedd D, et al 1999, *Voices of strength and resistance: A contextual and longitudinal analysis to women's responses to battering*. Journal of Interpersonal Violence 13 (6): 743 – 762
- CDC, 1998, *Management of possible sexual, injecting-drug-use, or other non-occupational exposure to HIV, including considerations related to Antiretroviral Therapy*, Public Health Service Statement, MMWR,47(RR17);1-14\
- Derbyshire H., 2001, *Gender Manual: a practical guide for development policy makers and practitioners*, Social Development Division, Department of International Trade, UK.
- Dey K, 2002, *Rape Trauma Syndrome and Delays in Reporting*, Rape Crisis Cape Town Trust. unpublished
- Farmer P, Connors M, Simmons J, (eds), 1996, *Women, Poverty and AIDS; Sex, Drugs and Structural Violence*, Partners in Health, Cambridge
- FIDA 2002, *Domestic Violence in Kenya – Report of a Baseline survey Among Women in Nairobi*. Nairobi; Apex Communications Ltd.
- Garcia-Moreno, 1999, *Violence Against Women, Gender and Health Equity*, in www.hsph.harvard.edu/organization/healthnet/Hupapers/garcia.html
- Garcia-Moreno, 2002, *Dilemmas and opportunities for an appropriate health service response to violence against women*, in The Lancet. Vol 359. April 27 2002:1509-1513
- Gelles, R.J., Straus, M., 1998, *Intimate Violence: the causes and consequences of abuse*, Simon & Schuster, New York.
- Gordon, P. and Crehan, K. 2000, *Dying of Sadness: Gender, sexual violence and the HIV Epidemic*, UNDP/SEPED Conference Paper Series, found in www.undp.org/seped/publications/conf pub.htm
- Government of Kenya, 2000, *Second Report on Poverty in Kenya (Volumes I and II)*, Ministry of Finance and Planning, Nairobi.
- Government of Kenya/Office of the President, 2002, *Mainstreaming Gender into the Kenya National HIV/AIDS strategic plan 2000-2005*. The Gender and HIV/AIDS Technical Sub-committee of the National AIDS control Council.
- Government of Kenya/Ministry of Health, 2001, *AIDS in Kenya: Sixth Edition*, Kenya
- Gupta R, Whelan, D, & Allendorf A, 2002, *Expert Consultation on integrating gender into HIV/AIDS programmes (Briefing note)*, ICRW; Washington DC
- Gupta R, 2000 *Gender, Sexuality and HIV/AIDS: The What, the Why and the How*, ICRW, Washington DC
- Gupta R, & Weiss E.,1993, *Women and AIDS,: Developing a New Strategy*, ICRW: Washington DC

- Heise L, Ellsberg M, & Gottemoeller M, (eds) 1999, *Population reports – Ending Violence Against, Population reports*, Series L, No. 11. Baltimore, John Hopkins University school of Public Health, Population Information Programme.
- Hudleson P, 1994, *Qualitative Research for Health Programmes*, Division of Mental Health, WHO, Geneva
- Jensen K, & Otoo-Oyortey, 1999, Gender based violence: an impediment to sexual and reproductive health, International Planned Parenthood Federation, <http://www.ippf.org/resouces/gbv/>
- Jewkes R, 2002a, *Intimate Partner violence: causes and prevention*, in *The Lancet*, Vol 359;1423
- Jewkes R, 2002b, *Preventing sexual violence: a rights based approach*, *The Lancet* Vol 360;1092-3
- Johnston T, *Gender Series: Violence and abuse of women and girls in Kenya; A briefing book*, Population Communication Africa in association with Ford Foundation, NCWK and CIDA/GESP, New World Printers, Kenya.
- Kahn J, Martin J, et.al, 2001, *Feasibility of Post Exposure prophylaxis (PEP) GAINST human Immunodeficiency Virus infection after sexual or Injection drug use exposure: The San Francisco PEP study*, *The Journal of Infectious Diseases*, Vol 183; 707-14
- Katz M, & Gerberding J, 1997, *Post exposure treatment of people exposed to the Human Immunodeficiency virus through sexual contact or injection drug use*, *The New England Journal of Medicine*, Vol 336, No.15;1097-1100
- Kibwana K, 2000, *Confronting Sexual Harassment and Abuse: The Kenyan Case*; in Kibwana K, & Mute L, (eds), *Law and the Quest for Gender Equality in Kenya*, Claripress, Kenya
- Kim J, 2001, *Integrating gender and gender based violence interventions and research into both VCT services and a poverty focussed HIV initiative in South Africa* in *Violence against Women and HIV/AIDS: Setting the Research Agenda*. WHO, Geneva
- Kitzinger J, 1995, *'Introducing Focus Groups'* *BMJ* 311:299-302
- Kilonzo N, Abuya T, et.al, 2002, *Sector Wide Approaches (SWAs): District level Opportunities and Challenges for gender mainstreaming in Kenya – Health Sector Planning*, in a resource pack by Theobald, Tolhurst & Elsey (eds) *Sector Wide Approaches: Opportunities and Challenges for Gender Equity in Health*, Women's World Conference, Uganda, July 2002. LSTM/LATH/Gender and health Group, UK
- Krishnan S, 2000, *Study on the links between marital violence and women's vulnerability to sexually transmitted diseases (STDs), Karnataka State, India*, in WHO, 2001, *Violence against Women and HIV/AIDS: Setting the Research Agenda*. WHO, Geneva.
- Krug, E, Zwi A, et al, 2002, *The world report on violence and health*, *The Lancet*, Vol 360;1083-8
- Laporte A, Jourdan N, et.al, 2002, *Post-exposure prophylaxis after non-occupation HIV exposure: Impact of recommendations on physicians experiences and attitudes*, *AIDS* Vol.16, No 3;397-405
- Maman S, Mbambo J, et al, 2001, *HIV and Partner Violence, Implications for HIV Voluntary Counselling and Testing in Dar es Salaam, Tanzania*, The Population Council Inc.
- Maman S, Campbell J, et al, 2000, *The intersections of HIV and violence: direction for future research and interventions*, *Social Science and Medicine* Vol 50, 459-78
- March C, Smyth I, & Mukhopadhyay M, 1999, *A Guide to Gender-Analysis Frameworks*, Oxfam, GB
- Martin S, Kilgalne B, et.al, 1999, *Sexual Behaviours and Reproductive Health Outcomes: Associations with wife abuse in India*, *Journal of the American Medical Association* 282:20; 1967 - 1972
- McCall J, & Shields, M. *Social and structural factors in family violence*. In Lystad M. Ed. *Violence in the home: Interdisciplinary perspectives*. New York,; Bruner/Mazel, 1986
- Mench B, 1996, *Locating adolescent: An overview of adolescents reproductive behaviour and its social consequences*. Presented at the World Bank: Washington DC

- Merchant R, & Keshavarz R, 2001, *Human Immunodeficiency virus post exposure prophylaxis for adolescents and children*, Paediatrics Vol.108, No 2. (<http://www.pediatrics.org/cgi/content/full>)
- Moore M, 1999, *Reproductive Health and Intimate Partner Violence in Family Planning perspectives* Vol.31, No.6, Nov/Dec 1999 found in www.qweb.kvinnoforum.se/papers/ ...
- Morison L, 2001, *Factors determining differences in rate of spread of HIV in sub-Saharan Africa: Results from a population-based survey in four African countries*, in WHO, 2001, *Violence Against Women and HIV/AIDS. Setting the Research Agenda*, WHO, Geneva
- Moser C, 1993, *Gender Planning and Development: Theory, Practice and Training*, Routledge, London
- Nyamu C, & Gathii J, 2000, *Towards Reform of the Laws on Rape and Related Sexual Offences in Kenya*, in Kibwana K & Mute L, (eds), *Law and the Quest for Gender Equality in Kenya*, Claripress, Kenya
- Opala K., 2002, *Uproar over rape by police*, Spotlight – gender violence, Daily nation/Tuesday, March 19;11.
- Patton M Q, 1990, *Qualitative Evaluation and Research Methods*. Sage Publications, UK
- Randall R., 1997, *Mapping a Global Epidemic: Review of Current literature on rape, Sexual Assault and Sexual Harassment of Women Consultation on Sexual Violence Against Women*, Institute on Race, Health Care and the Law, University of Dayton School of Law, Ohio.
- Reinharz, 1992, *Feminist Methods in Social Research*, Oxford University Press, Oxford
- Republic of Kenya/ Ministry of Finance and Planning, 2002a, *Nairobi Development Plan 2002-2008: Effective Management for Sustainable Economic Growth and Poverty Reduction*, Government Printer, Kenya
- Republic of Kenya/ Ministry of Finance and Planning, 2002b, *Malindi District Development Plan 2002-2008: Effective Management for Sustainable Economic Growth and Poverty Reduction*, Government Printers, Kenya
- Republic of Kenya/ Ministry of Finance and Planning 2002c, *Thika District Development Plan 2002 – 2008: Effective Management for Sustainable Economic Growth and Poverty Reduction*, Government Printers, Kenya
- Republic of Kenya, 2002d, *National Development Plan 2002 – 2008: Effective Management for Sustainable Economic Growth and Poverty Reduction*, Government Printers, Kenya
- Roland M, 2002, *Prophylaxis following non-occupational exposure to HIV*, HIV InSite Knowledge Base Chapter in <http://hivinsite.ucsf.edu/insite>
- Roland M, Martin J, et. al, 2001, *Post-exposure prophylaxis for HIV infection after sexual or injection drug use exposure: Identification and Characterization of the source of exposure*, The Journal of Infectious Diseases, Vol184; 1608-12
- Rompay K, Miller D, et al. 2000, *Prophylactic and Therapeutic Benefits of Short-Term 9-[2-(R)-Propyl] Adenine (PMPA) administration to newborn Macaques following oral inoculation with SIV with reduced susceptibility to PMPA*, Journal of Virology, Vol 74. No.4;1767-1774.
- Royce R, Sena A, et al, 1997, *Sexual Transmission of HIV*, The New England Journal of Medicine, Vol, 336, No.15;1072-8
- Sen G, George A, Ostlin P, (eds), 2002, *Engendering international health: The Challenge of Equity*, Massachusetts, US
- Sen G, 1997, *Subordination and Sexual Control: A Comparative View of the Control of Women*, in Visvanathan N, (eds) *The Women, Gender and Development Reader*, Zed Books, UK
- Shrader E, 2001, *Methodologies to measure the gender dimensions of crime and violence*, Gender Unit, Poverty Reduction and Economic Management, World Bank.
- Smith D, 2001, *HIV post exposure prophylaxis and sexual assault: a brief overview*, WHO, *Violence Against Women: Setting the Research Agenda*, Geneva.

Tallis V., 2002 *Gender and HIV/AIDS – Overview report*; the cutting edge pack, Bridge development-gender Institute of Development Studies, UK.

UNAIDS, 1999, *Taking Stock of Research Programmes on Gender and HIV/AIDS*, UNAIDS, Geneva.

Wade N, Guthrie S, et al, 1998, *Abbreviated regimens of Zidovudine prophylaxis and Peri-natal transmission of the human immunodeficiency virus*, The New England Journal of Medicine Vol.339, No.20;1409-1414

Watts C., 2001, *Violence against Women: Its importance for HIV prevention and care activities*, in WHO, 2001, *Violence Against Women and HIV/AIDS: Setting the Research Agenda*. WHO, Geneva

WHO, 2001, *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women*, WHO/FCH/GWH/01.1, WHO, Geneva

WHO, 2001, *Violence against Women and HIV/AIDS: Setting the Research Agenda*. WHO, Geneva.

WHO, 2002. *Facts on Sexual Violence – a data sheet*, found in <http://www.who.int/violence-injury-prevention>.

Wilkinson S, *Focus Group Methodology: a review*, International Journal of Social Research Methodology, Vol 1, No 3:181 - 203

ANNEX 1: DATA SUBMISSION FORM

Coding: month year/ study/ District code/ data collection type - serial number

e.g 0203/GBV/206/FGD - 1

DATA SUBMISSION FORMS

Date	Type of data /report	OQ	Checklist							Hand in	sign	Rec
			notes	CSS	Trans	sumnot	tape	questn	rpt type			
	GBV											

Key: Notes: Notetakers notes Sumsht: Context summary sheet Trans: Transcriptions Sum
 Tapes: recorded tapes of the session Questn: Questionnaires rpt type: Report type

Type of data collected; e.g semi-structured interviews (SSIs), key informant intervies (KIs), Group discussions (GDs)

Liverpool VCT & Care Kenya

ANNEX 2: FOCUSSED GROUP DISCUSSION GUIDELINES

Notes:

- Based on the information needs we identified, please practise the FGD with these questions.
- Understand them, test them and see how they can be applied.
- Feel free to make any changes, modifications, etc that we can discuss after the practise sessions

General opener

What do you know about HIV??

Probe for methods of transmission and tease out sexual violence (rape/sodomy) as one mode of transmission

Keep in mind that this is a sensitive and potentially explosive area surrounded by norms, taboos, beliefs and stigma. It needs to be approached with caution and the counsellor should be able to read the group.

Read → *Think* → *Act*

What do you understand by rape/sodomy

Probe about whether it happens here? Keep these questions/issues in mind.

Probe – keeping in mind the following questions

Remember, if there were some cases identified, the moderator could use these as a reference point and make connections to the normal occurrences

How are cases/situations resolved?

Were/are they reported to the police or/and taken to hospital or VCT site

In what circumstances are they reported to the police?

Who does/did the reporting?

What happens at the police station?

Who accompanies (d) the raped person?

What happens at the hospital? Are the staff there supportive?

Are there any charges for these services?

Are there any extra costs?

How affordable are these?

Do you feel that the police are/were helpful?

What can they do to be more helpful?

What can they do to be more helpful?

What other services and support is available in the community

What other organizations/institutions provide support to rape survivors in the community??

What sort of support is provided??

What type of support should they be providing??

What constraints are faced by those who have been raped and their families?

In your opinion what can be done

What can be done to minimize these constraints?

What can be done to stop rape?

Who should be involved? And how?

Keep VCT in mind at this point so that if it comes up in the discussions, it can be followed up and if not, remember to ask whether VCT has any role in this.

What is VCT?

Do you think it is useful?

If so, how?

ANNEX 3: KEY INFORMANTS DISCUSSION GUIDELINES

LEGAL SERVICES

- i. What is the definition of rape in Kenya
- ii. What generally does the law say about rape??
- iii. What are the laid down procedures and requirements for rape reporting
- iv. What is the procedure for prosecution??

Probe for a description of a step to step guide on what a person who has been raped should do??

Who can give admissible evidence in court – clinicians, doctors, counsellors; minors;

- v. Do you think that this system is functional??
- vi. What needs to be done to enhance this system??
- vii. There are many people who are involved in rape cases – police-doctors-advocates- judicial system etc

Do you feel that they have the required competency in knowledge and legal requirements and processes to support survivors??

What should be done??

- viii. In what ways can legal support groups engage law enforcement towards addressing rape as an issue?
- ix. What is the responsibility of the Government towards provision of legal support to rape survivors??
What makes you think so?
- x. In your opinion, are the legal provisions we have for support of rape survivors adequate?
- xi. What are the constraints/challenges that rape survivors face from a legal perspective??
- xii. What can be done to get more people to report and seek post-rape services??
- xiii. What are the constraints towards provision of adequate legal services?
- xiv. What are the opportunities?

TO SPECIFIC ORGANIZATIONS

- xv. What is the responsibility of legal support organizations towards rape survivors who come to you for your services?
- xvi. Are there any conditions for support of clients?
- xvii. What legal services do you offer your clients?
- xviii. What other/support services do you offer the clients?

THE POLICE

- i. What is the standard procedure in the event of a person reporting assault/rape??
Probe for whether the procedure has been written down and whether it is followed
- ii. Are there specific questions/issues that you are supposed to ensure that you capture when during reporting??
- iii. After rape has been reported to your stations, what specific actions do you undertake?
- iv. What does the law say about investigation and prosecution in rape cases?
Requirements, laws,
- v. What is the role of the police in this process??
- vi. Do you feel that the police accomplish this role as stipulated by law??
What makes you feel so??
- vii. Do you feel that the police accomplish this role as expected by the public??
What makes you feel so??
- viii. Do you refer rape survivors once they report to you?
- ix. Where do you refer them??
- x. How many rape cases were reported in this station in the last one year? Two years??
- xi. How many of these rape cases were you able to prosecute??
- xix. What is the responsibility of the Government towards provision of legal support to rape survivors??
What makes you think so?
- xx. What in your opinion should the police be offering to support rape survivors??
- xxi. In your opinion, are the provisions we have for support of rape survivors adequate?
- xxii. What are the constraints/challenges that rape survivors face from your perspective??
- xxiii. What can be done to get more people to report and seek post-rape services with the police??
- xxiv. What constraints do the police face in delivering services to rape survivors?
- xxv. What opportunities do you see in enhancing service provision?

RAPE MANAGEMENT/PEP PROTOCOL

- i. Is there a standard rape management protocol used??
From the MoH, KMA, WHO etc
Do you have any comments on this protocol – modifications, alterations etc
- ii. Have you heard about the evidence collection kit from KMA??
What do you feel about it?? – is it fine, does it need modification?? In what way??
- iii. Is there a standard forensic examination procedure??
Do you have copies of the procedure?? Have you seen it?? Do you know where I can get it??
- iv. Who is supposed to do the tests??
- v. In institutions where are they generally done??
- vi. What happens to the samples?? Where are they stored?
By who??, To whom can they be availed??
- vii. What is the system for maintaining the ‘chain of evidence’??
 - i. What is the general practice in the provision of post rape service
 - Once the client reports to the police station?? To the hospitals??
 - During examination
 - In follow up support
- i.
- ii. Are there an existing PEP provision guidelines and/or national protocol??
- iii. What other regimens are being offered for post rape to reduce risk of transmission of HIV
- iv. Is PEP being provided as part of rape services??
- v. Who is offering PEP??
Public institutions, private institutions,
- vi. What in your opinion is the capacity for ARV prescription and administration in Kenya??
Are Doctors/clinicians generally trained in HIV care and management?, test requirements for PEP provision,
Can these tests be done in any public hospitals,
Is there any existing training package in the country for already practicing Doctors/clinicians??
- vii. Are there any adherence to PEP issues, you see arising??
Probe..... which ones?? How can they be dealt with??
- viii. What support can be given to clients to enhance adherence to drugs??
- ix. Any ideas of follow-up mechanisms that may be put in place to support the client and enhance adherence??
- x. Given that a number of rape clients visit VCT centres for support, what could be done to provide/support post rape services within VCT sites??
Clinical management?, examination??, counselling??,

COUNSELING AND SUPPORT

- xi. Do we have adequate counseling services for rape and subsequent trauma in Kenya and in our hospitals??
- xii. Who/where are these services being provided??
- xiii. Who is providing the training for counselors??
- xiv. In your opinion, are rape survivors adequately supported in counseling??

Probe for feeling and what more needs to be done, who should be involved in doing it??

- xv. Infrastructure for counselling support??
- xvi. What other support is provided from counselling institutions – advise on legal systems??
Advise on
- xvii. Who provides counselling supports
Probe.....e.g Government hospitals, churches,
Names of any specific ones??
- xviii. What referral mechanisms are in place between counselling organizations and other rape care service providers??
Does anything need to be done to enhance referral?? If so what?? Who should do it?? What is their responsibility??
- xix. Given that PEP goes hand in hand with HIV testing, what in your opinion should be done to:
Reduce trauma??
Prepare the client adequately for the possibility of sero-positivity at this traumatic time??
Increase capacity of counsellors for dealing with double trauma of clients
- xx. What in your opinion is the responsibility of the government towards support of rape survivors??
- xxi. What systems should be institutionalised to enhance counselling and support for rape survivors??

GENERAL QUESTIONS TO ALL KEY INFORMANTS

- i. Are you in any way working with partners of your clients?
If so, how?
- ii. What other activities are you involved in? (policy dialogue, etc)
- iii. What challenges do you face on a day to day basis?
- iv. What linkages do you have with different service providers?
- v. Do you have any follow up/tracking mechanisms of your rape survivors?
- vi. What in your opinion is the responsibility of the health system towards its GBV clients?
- vii. What in your perception is the responsibility of law enforcement and judicial system for rape survivors?
Is this responsibility being carried out effectively? Why do you think so?
- viii. What are the constraints/challenges to provision of adequate support services to your GBV/Sexual assault clients?
- ix. What are the opportunities for provision/ improvement of these service?