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

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

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

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

Relevant changes A standard of care and a simple post-rape care systems algorithm were designed. A counselling protocol was developed. Targeted training that was knowledge-, skills- and values-based was provided to clinicians, laboratory personnel and trauma counsellors. The standard of care included clinical evaluation and documentation, clinical management, counselling and referral mechanisms. Between early 2004 and the end of 2007, a total of 784 survivors were seen in the three centres at an average cost of US$ 27, with numbers increasing each year. Almost half (43%) of these were children less than 15 years of age.

Lessons learned This paper describes how multisectoral teams at district level in Kenya agreed that they would provide post-exposure prophylaxis, physical examination, sexually transmitted infection and pregnancy prevention services. These services were provided at casualty departments as well as through voluntary HIV counselling and testing sites. The paper outlines which considerations they took into account, who accessed the services and how the lessons learned were translated into national policy and the scale-up of post-rape care services through the key involvement of the Division of Reproductive Health.

Introduction

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

Kenyan context

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

A situation analysis in 2003 revealed limited post-rape services, lack of policy and tensions between HIV and reproductive health staff at service delivery points. Facilities lacked protocols and confidential spaces for treatment. Beyond a requirement that examinations be undertaken by a doctor, there were no reporting requirements and an absence of monitoring and evaluation of services. Furthermore, survivors were required to pay for drugs and services in public institutions. Where HIV-test counselling existed, it was delivered in the context of voluntary counselling and testing (VCT). Formal counselling for sexual trauma, where it existed, did not give consideration to HIV testing.

System development process

A standard of care was developed in selected districts. In collaboration with a Kenyan nongovernmental organization (Liverpool VCT, Care & Treatment) services were established in government health facilities in three disparate districts in

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

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

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

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

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

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

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

### Initial challenges

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

Counsellors also experienced uncertainty around shared confidentiality: the rights of the survivor in relation to those of the counsellor to disclose results for medical reasons or when the survivor was a sexually active minor. Currently, the lack of a cadre of counsellors in the Kenyan government system has hampered post-rape care. Many health-care workers end up doing HIV testing and also trauma counselling in addition to their normal duties. This translates into provider stress, high...
attrition rates and inconsistent service delivery that challenge the investment in capacity building described in this paper.

**Uptake and client satisfaction**

By the end of 2007 a total of 784 survivors of sexual violence had been seen in the three sites, with 43% of them young people (predominantly girls) aged less than 15. Of these 84% arrived in time to be eligible for PEP. There was one known seroconversion of a previously HIV-negative girl, who had reported repeated abuse by an uncle. Client exit interviews conducted with survivors or their guardians in 2005 indicate a high level of satisfaction with the services. No information on prosecution and conviction rates of perpetrators is available but anecdotally these are very low.

**Using lessons to inform policy**

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

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

The potential to improve relationships between the health sector and justice systems has not been realized in Kenya. Specimen collection of sufficient standard to provide evidence in court was undermined by the lack of commercial specimen collection kits or availability of additional requirements such as tamper evidence seals, replacement clothing and specula suitable for children. In addition there was a lack of DNA profile testing. We were unable to determine how many of the survivors received legal support or the role played by the evidence that was collected. This remains a practical and policy gap in the provision of post-rape care.

**Conclusion**

Kenya has seen a rapid policy response to the documented need for post-rape care services among both adult and child survivors. Key lessons learned (Box 1) were: the importance of a participatory policy development process;

**Box 1. Summary of lessons learned**

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

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

<table>
<thead>
<tr>
<th>Counselling</th>
<th>Laboratory</th>
<th>PEP follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>- If &lt; 72 hours, give 1st dose of PEP (up to 6), consider emergency contraception</td>
<td>- HIV antibody test</td>
<td>- Week 0: dispense PEP for 2 weeks</td>
</tr>
<tr>
<td>- If &gt; 72 hours, PEP and emergency contraception are not appropriate</td>
<td>- Specimen analysis</td>
<td>- Week 2: dispense PEP for 2 weeks, discontinue if significant side effects</td>
</tr>
<tr>
<td>- Clinical evaluation</td>
<td>- If on PEP, baseline bloods to include Hb, SGPT, CR</td>
<td>- Week 4: review symptoms, offer HIV testing</td>
</tr>
<tr>
<td>- Legal documentation</td>
<td>- If Hb &lt; 6.5, SGPT &gt; 175 or CR&gt; 3, consult senior clinician before continuing PEP</td>
<td></td>
</tr>
<tr>
<td>- STI prophylaxis</td>
<td>- HIV post-test counselling</td>
<td></td>
</tr>
</tbody>
</table>

- HIV pre-test (allow up to 3 days to decide on HIV testing if on PEP)
- If on PEP provide PEP adherence counselling
- Trauma counselling

- CR, creatinine; Hb, haemoglobin; PEP, post-exposure prophylaxis; SGPT, serum glutamic pyruvic transaminase; STI, sexually transmitted infection.
en 2002 empezamos a trabajar a través de las Division de la santé génésique. Los modelos de prestación de servicios integrados a las víctimas recientes de una violación proceden en su mayoría de países con abundantes recursos y no pueden exportarse fácilmente a otros entornos con recursos limitados, como por ejemplo Kenya, aunque se reconozca la necesidad de tales servicios y pese a la centralidad de inciden de la san en Ken en la atención a las víctimas de violación gracias a la decisiva implicación de División de Salud Reproductiva. La norma de soins couvrant l’évaluation clinique y las lecciones tiradas del presente artículo décrit comment les équipes multisectorielles de district au Kenya sont convenues de fournir une prophylaxie post-exposition, un examen physique y des services de victorias recientes de una violación proceden en su mayoría de países con abundantes recursos y no pueden exportarse fácilmente a otros entornos con recursos limitados, como por ejemplo Kenya, aunque se reconozca la necesidad de tales servicios y pese a la centralidad de inciden de la san en Ken en la atención a las víctimas de violación gracias a la decisiva implicación de División de Salud Reproductiva. La norma de soins couvrant l’évaluation clinique y las lecciones tiradas del presente artículo décrit comment les équipes multisectorielles de district au Kenya sont convenues de fournir une prophylaxie post-exposition, un examen physique y des services de victorias recientes de una violación proceden en su mayoría de países con abundantes recursos y no pueden exportarse fácilmente a otros entornos con recursos limitados, como por ejemplo Kenya, aunque se reconozca la necesidad de tales servicios y pese a la centralidad de inciden de la san en Ken en la atención a las víctimas de violación gracias a la decisiva implicación de División de Salud Reproductiva. La norma de soins couvrant l’évaluation clinique y las lecciones tiradas del presente artículo décrit comment les équipes multisectorielles de district au Kenya sont convenues de fournir une prophylaxie post-exposition, un examen physique y des services de victorias recientes de una violación proceden en su mayoría de países con abundantes recursos y no pueden exportarse fácilmente a otros entornos con recursos limitados, como por ejemplo Kenya, aunque se reconozca la necesidad de tales servicios y pese a la centralidad de inciden de la san en Ken en la atención a las víctimas de violación gracias a la decisiva implicación de División de Salud Reproductiva. La norma de soins couvrant l’évaluation clinique y las lecciones tiradas del presente artículo décrit comment les équipes multisectorielles de district au Kenya sont convenues de fournir une prophylaxie post-exposition, un examen physique y des services de victorias recientes de una violación proceden en su mayoría de países con abundantes recursos y no pueden exportarse fácilmente a otros entornos con recursos limitados, como por ejemplo Kenya, aunque se reconozca la necesidad de tales servicios y pese a la centralidad de inciden de la san en Ken en la atención a las víctimas de violación gracias a la decisiva implicación de División de Salud Reproductiva. La norma de soins couvrant l’évaluation clinique y las lecciones tiradas del presente article décrit comment les équipes multisectorielles de district au Kenya sont convenues de fournir une prophylaxie post-exposition, un examen physique et des services de prévention des infections sexuellement transmissibles et des grossesses. Ces présentations ont été délivrées dans les services d’urgence, ainsi que dans les centres de conseil et de dépistage volontaire du VIH. L’article indique les considérations prises en compte par ces équipes, les personnes ayant accès à ces services, la façon dont les enseignements tirés ont été transposés en politiques nationales et le développement à plus grande échelle des services de soins après un viol grâce à l’implication clé de la Division de la santé génésique.

Acknowledgements
We thank all the health-care providers that participated in this intervention.

Competing interests: None declared.
إيئات خدمات تكوين الاغتصاب: خبرة كينية في إعداد الخدمات المتكاملة

المشرف: توفر المعلومات عن خلايا إيئات الخدمات الشاملة تكوين الاغتصاب بشكل كبير من البلدان الغنية بالموارد ولا يمكن ترجمتها بسهولة إلى المواقع المحدودة الموارد مثل كينيا. وذلك رغم تبني الحاجة إلى تلك الخدمات، فإن المواقع المحدودة الموارد لا يمكن ترجمتها بسهولة إلى المواقع المحدودة الموارد.

الأسباب: بدأ الباحثون بالعمل سنة 2002 من خلال تواجد الخدمات الشاملة تكوين الاغتصاب في كينيا. وتشمل هذه الخدمات: خبرة كينية في إعداد الخدمات المتكاملة تكوين الاغتصاب، كما تم إعداد بروتوكول إرشادي، وتم تقديم التدريب الموجَّه من خلال الهياكل الحكومية المحدودة الموارد.


واجدت كل عام؛ وكان ما يقرب من نصف هؤلاء الأطفال الذين تلقوا الرعاية للإيدز، كانون الثاني 2003.

التعليمات: تصف هذه الورقة فرقاً متعددة القطاعات في مستوى دولة أمريكية، وتشمل هذه الورقة الاختبارات التي أخذت بالحسبان، وكيف ترجع هذه الخدمات المتكاملة إلى سياسات وطنية. وتم توزيع هذه الخدمات من خلال النيابة العامة لعلاج الأمراض المعدية بفيروس الإيدز.

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559

N Kilonz et al.

Post-rape care services in Kenya

MLK55

N Kilonz et al.