
# Implementing post rape care services in Public Health Settings: Challenges & Opportunities

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# Why post rape care?

**impetus...**

- health workers reports & SV clients in VCT

**operational research**

- diagnosis – situation analysis
- Intervention
- evaluation

# Diagnosis (situation analysis) phase

- perceptions of rape/sexual violence in Kenya
  - 3 districts (Nairobi, Malindi, Thika)
  - 18 FGDs – 5 adolescent male/6 female; 3 adult female & 2 male; 2 CSWs
- situation & priorities for post rape care services
  - 36 key informant interviews (health providers – clinicians, counselors; policy makers, police)

# Findings (perceptions of SV in Kenya)

- fuzzy boundaries ‘force, coercion & consent’
  - ‘women say no when they mean yes’
- health providers difficulties
  - initiating HIV counselling for survivors
  - HIV sexual risk with survivors
  - documentation of occurrence history – dependent on survivor age & gender

# ...'force, coercion or consent'...

"*Lets say I have a boyfriend and am against the act, but you can be forced. He will come at night when he knows I am there because he want to do …, and to make me to give him. He knows if he rapes me, I will be disappointed and when others get to know,* they will reject and laugh at me saying I was raped – *so I will give in*" (adolescent female, 16yrs, Thika)

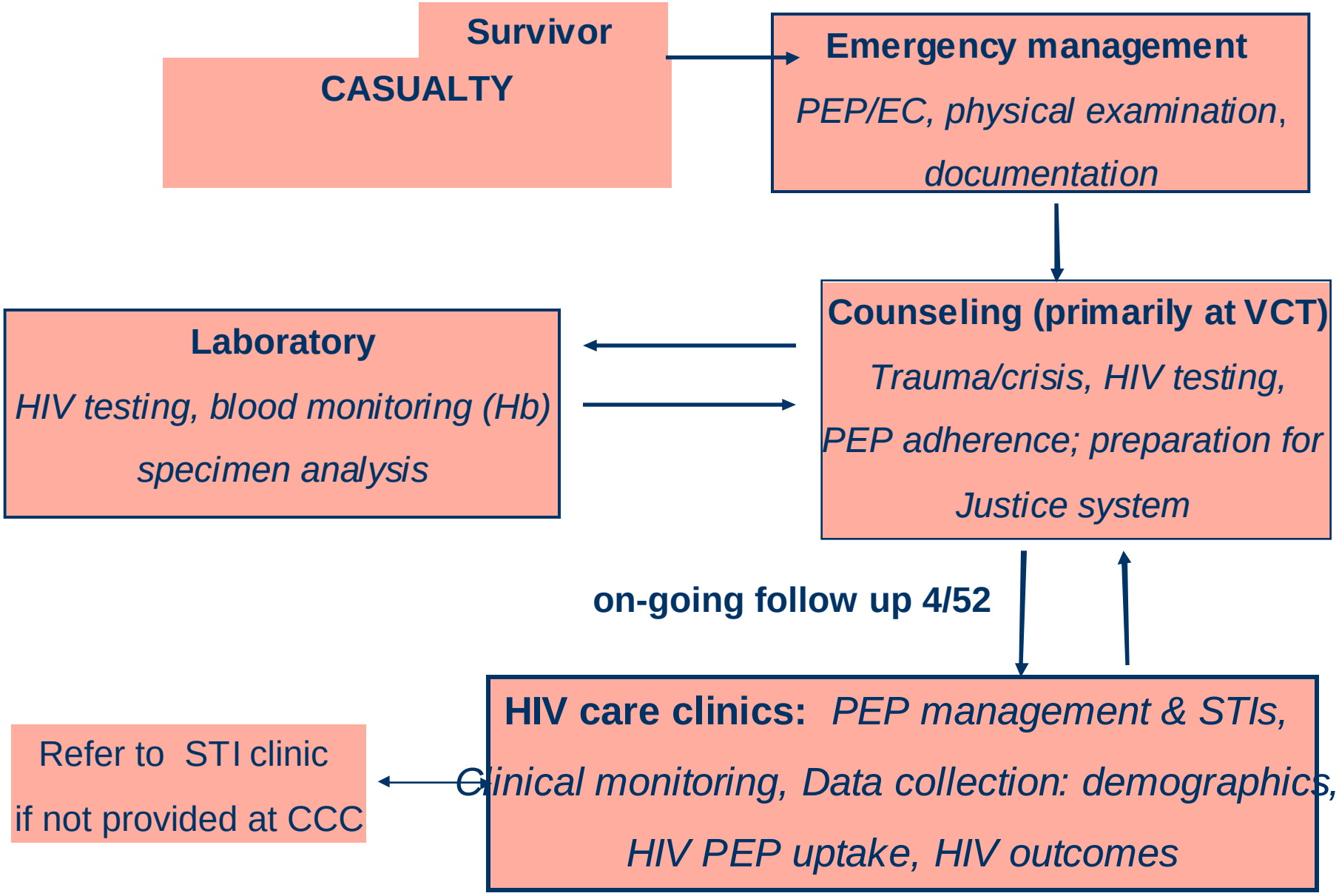
# Findings (post rape care service delivery)

- policy level
  - no regulatory framework & standards
  - no coordination , documentation
- service delivery level
  - inconsistent services: EC, STI/ HIV prevention (PEP); counseling – trauma; HIV testing; PEP adherence
- limited capacities – human, technical, financial
- high user costs – cards, fees

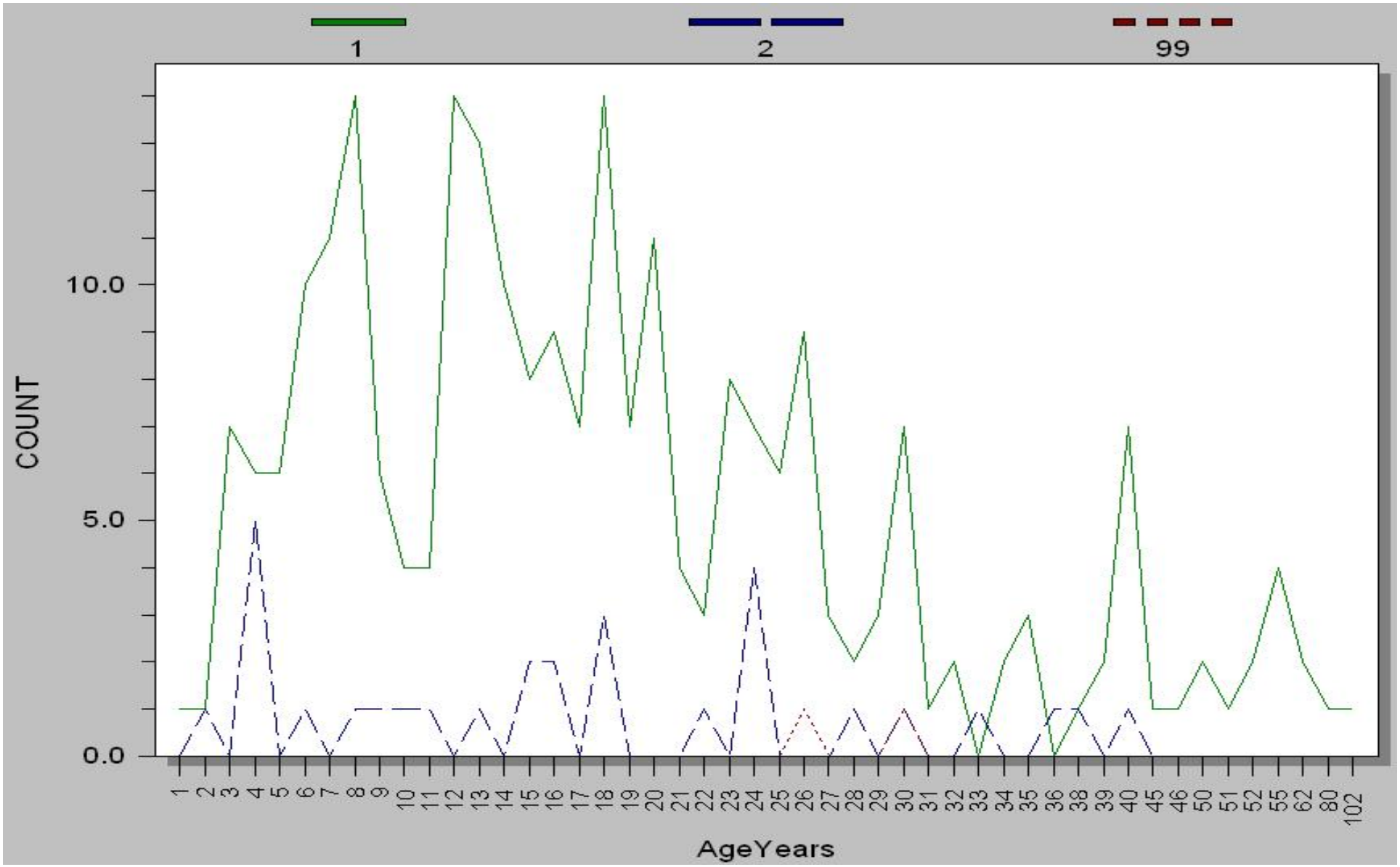
# Intervention process – Participatory Action Approaches

- stakeholder consultations - DHMTs
- 'PRC systems algorithm' – consensus process
  - standards, protocols; procedures, client flow
- records/documentation – mutually defined outcomes
- targeted health provider training & investigated personal values towards SV
  - clinicians/nurses/laboratory personnel & trauma counselors

# Delivering the standard of care



# Client distribution by age & sex (n=386)



# Uptake of services

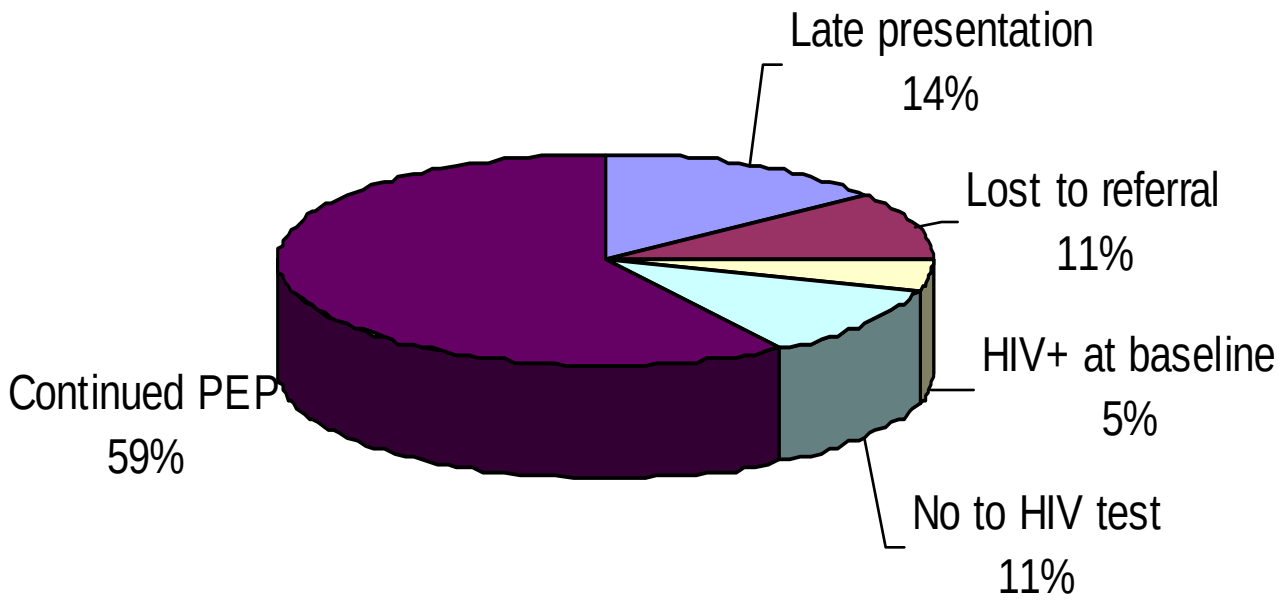
- Thika 257; Malindi 83; Rachuonyo 46
- median age – 16.5  IQR (9,25)
- age range of cohort (16 months – 102 years)
- 88% female (Malindi – 24% males)
- 56% children (<18years)
- children more likely to know perpetrator/s (OR 6.2; p=0)
- **all** (15%) late presentations knew assailant

# Delivery: Quality of clinical management (n=292)

of the cohort

- eligible females - 88% got EC
- 74% - lab services
- 73% - STI prophylaxis
- 56% - physical examination & documentation
- 50% counselling; 50% information

## Delivery: Quality of PEP delivery (n=292)




- 51% PEP completion
- 16% loses in client flow pathway
- those counseled more likely to complete PEP (OR 2.7; p=0.004)
- 1 sero-conversion – 7yr old, female

# Acceptability of the PRC service

- services owned by DHMTs
- documentation – key to link to local HMIS
- health providers acknowledged training as important
- targeted training considered key
- clinical outcomes linked to social considerations by SPs – PEP non-adherence and non completion linked to non-disclosure of SV, HIV testing

# Lessons learnt

- base standard of care on local health systems
- targeted & value based training for SPs
- positive prevention for survivors
- chronic exposures – should PEP be delivered?
- contextual HIV risk for adult/ adolescent - consent, force & coercion – role of rights advocacy?
- counselling & active follow up are key

# Acknowledgements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