Appraisal of the coordination system for GBV prevention and response: Samburu, Bungoma and Kilifi counties

Final report: 18 December 2024

Acknowledgements

This report was prepared by Anna Nordenmark Severinsson, international capacity building expert and Milka Kariuki, local capacity building consultant for the Kenya-Finland bi-lateral programme on GVB prevention and response. The data informing the present report was collected by the two consultants with Ms. Nordenmark Severinsson leading national interviews and consultations, and the first week of data collection in Bungoma. Ms. Kariuki continued data collection in Samburu and Kilifi County independently. During data collection, interviews were recorded in writing with detailed interview notes. Data was analyzed and findings prepared through a comparison of interview notes between counties, and during multiple joint drafting sessions where both consultants exchanged and agreed on findings based on the cross-county comparison on interview materials. Ms. Nordenmark Severinsson was the lead author of this report.

The team of consultants are very grateful to Michelle Dawn Ell, Senior Technical Advisor of NIRAS to the Kenya-Finland bi-lateral programme, and to Yvonne Mwenda Programme Technical Officer of NIRAS, who were instrumental in providing context, constructive comments, guidance and facilitating the data collection for the present appraisal.

The consultants would also like to acknowledge the important role of the Programme Management Team (PMT), with whom the consultant met as a team, and also individually. The PMT validated the methodology, facilitated access to respondents and provided very constructive comments on preliminary findings, shared in a meeting on the 16 May 2024.

Executive summary

Introduction:

Gender-Based Violence (GBV) is a pervasive issue that affects individuals globally, with significant consequences for the well-being of individuals and communities. In Kenya, GBV remains a critical concern, impacting the lives of many, particularly women and girls. The Kenya-Finland Bilateral Programme on Strengthening Prevention and Response to Gender-Based Violence (GBV) in Kenya began in 2022 and will conclude implementation in December 2024. Its primary goal is to reduce GBV and harmful practices with the expected outcomes of:

- Enhanced governance and coordination of policy implementation, through strategic planning, and budgeting for GBV;
- Establishment and strengthening of Quality GBV Services, Systems and structures that are sustainable at the national level and in Bungoma, Kilifi, and Samburu counties; Strengthening the moral and legal duty bearers' capacity to better identify, address, and prevent GBV; and
- Community Engagement including of marginalized groups and champions in GBV prevention and response efforts.

Objective:

The primary objective of this appraisal was to collect data on coordination roles and responsibilities of various cadres with leadership, supervisory, professional and volunteer to inform the understanding of the organization of the GBV sectors and how coordination is undertaken within sectors and between sectors of the government. The assessment seeks to propose to the gender ministry on how to strengthen coordination further to improve the functionality and performance of GBV prevention and response services.

Assessment framework:

To assess coordination, the appraisal organized the coordination function around two different purposes: namely (i) functional coordination within and between sectors to manage cases of GBV; and (ii) policy coordination to inform strategic planning, monitoring, evaluation and learning within the system.

Methodology:

The appraisal focused on key sectors responsible for documenting cases and coordinating efforts, including peace and security, health, law enforcement represented by the police service and justice officers, children's services, gender, and education. The appraisal was a rapid assessment and was informed from a desk review and a one week of data collection per county from a sample size of 87 key informant interviews in March and April 2024. Data was collected in Samburu, Bungoma, and Kilifi counties and with the corresponding national-level oversight structures. The appraisal focused

on frontline duty bearers within these sectors to understand their roles in the GBV prevention and response to provide a comprehensive understanding of the coordination mechanisms in place and how they contribute to GBV prevention and response efforts.

Findings:

Policy and governance

The appraisal revealed both progress and persistent challenges in the coordination of the GBV prevention and response in the counties. The appraisal noted that each of the three counties – Bungoma, Kilifi and Samburu - has a functioning multi-sectoral system for GBV prevention and response, that could be better leveraged if each sector understood the role of other sectors in prevention, reporting and response to GBV. In addition, the GBV prevention and response system has reach and representation to the grassroots level, with Chiefs as unique assets in the system that can be leveraged through training at scale for awareness raising, prevention and a role in early warning. While significant efforts have been made to address GBV through policy reforms and awareness campaigns, gaps in service delivery, resource allocation, and coordination among stakeholders remain a challenge.

Functional coordination: case management, referrals and escalation of cases

Functional coordination for case management, referrals, and escalation of cases is undertaken by various sectors. The appraisal assessed sectoral roles for those functions, level of specialization to ensure quality outcomes of case management for GBV survivors; how and if referrals and escalation of cases is done; clarity on roles to undertake those functions, capacity, and trust between professionals and sectors. The appraisal also looked into practices of professional supervision, peer support and guidance.

The appraisal noted that it is professionals from the health, police, children's services and the justice sectors mainly that take on functions related to functional coordination, whereas the gender sector is mainly involved in policy coordination in the three counties. The actors in the three counties seem clear about their sectoral roles and the need for coordination and collaboration in resolving cases but less clear on functional coordination in preventing cases.

Policy coordination

Policy coordination includes functions for strategic planning and therefore the appraisal assessed the vision; planning roles, capacity and tools for planning, including tools for data collection, data storage, data sharing and practices for planning and prioritization; and availability and functioning of mechanisms / platforms for coordination.

One of the challenges faced by the gender sector in implementing its policy coordination role is that there does not seem to be a clear and shared vision of the multi-sectoral GBV prevention and response system yet. The gender sector plays an important role in policy coordination, but this

function appears to be difficult to implement to limited data sharing practices. The gender sector does not currently 'own' the data on cases, and there is no obligation for other sectors to share data with the gender sector. There is also limited practice in using data for programmatic monitoring and performance evaluation. The planning tools – a seasonal calendar that identifies high-risk events and times of the years, as well as a geographic map indicating hotspots areas - introduced by the programme was referred to as something of an innovation. Each county has multiple coordination platforms operating in paralell. While the Gender Technical Working Group is referred to as functioning well, coordination platforms like GSWG are often dependent on donor funding and remain active as long as there is an injection of such funds but go dormant when programmes end.

Since gender sector is not represented with frontline officers at the grassroots, it seems to have a more relevant role in policy coordination, than in functional coordination. However, the unique and distinct value of policy coordination in driving the effectiveness of the GBV prevention and response system does not yet seem entirely clear to stakeholders . While functional coordination is guided by a variety of guidelines, tools and SOPs, policy coordination is a function that is integral to the functioning of the public administration and its professionals. Coordination is described in the job descriptions of the gender officers, but it is not detailed exactly what this coordination role entails. They need training, guidelines, tools and forms that set out the policy coordination, strategic planning duties, activities and key performance indicators for which they should be held accountable. ..

The appraisal noted that with so many different sectors and actors involved in the GBV prevention and response system in the three counties, the organization of the system is very complex with a mix of national delegated functions and decentralized functions, with governments still in the process of defining their optimal role in the GBV system and the coordination of that.

Conclusions:

The appraisal underscores the importance of a well-coordinated multi-sectoral system to address GBV in Kenya comprehensively and that such coordination has different purposes – function on cases and policy coordination to direct and progressively improve the systemic response to cases. The implication of this finding is that system strengthening initiatives for legal duty bearers should explore the potential of strengthening capacity comprehensively both policy and functional coordination.

For functional coordination, it is important to strengthen system stakeholders core competencies to create a common baseline of professional knowledge and skills to make prevention and response activities to GBV cases more predictable to all involved. For policy coordination, system stakeholders need training in collecting and interpreting data to inform strategic planning, monitoring, evaluation activities. There is also need for good communication, management and leadership skills to be able to rally multiple sectors around a common cause.

Going forward, programmes aiming to support policy coordination for GBV prevention and response could leverage capacity strengthening activities with broader governance, public sector and ICT reforms to facilitate their adaptation and implementation in the GBV multi-sectoral system. By implementing the recommendations outlined in this report, Kenya can strengthen its capacity to prevent and respond to GBV effectively, promoting a society where all individuals can live free from violence and discrimination.

Recommendations:

To strengthen the functional and policy coordination of the GBV prevention and response system in the three counties, several recommendations are proposed:

1. Facilitate a measurably survivor centered multi-sectoral GBV prevention and response system through: (i) defining more clearly the different coordination functions; (ii) strengthening the understanding among sectors and practitioners of the goals and vision of a well-functioning GBV prevention and response system; (iii) reviewing, adapting and selecting core policy relevant indicators from the National Monitoring and Evaluation Framework for the GBV policy for use and reporting to the gender sector in the 3 counties (iv) institutionalize framework through necessary regulation and a dashboard for the gender sector that helps to measure the effectiveness, efficiency and survivor centeredness of the GBV prevention and response system.
2. Develop an investment case and strengthen budgeting for a seamless continuum of GBV prevention and response services through: (i) a study that estimates in financial terms, the loss to society resulting from the current GBV-prevalence, and also the gains, if sufficient investments are made to address the gaps in training and logistics of the stakeholders included in the multi-sectoral GBV prevention and response system; (ii) forecast rate of returns (RAR) of investment over a 20–30-year period; (iii) undertake an expenditure review and compare results with investments needed as per investment case; (v) use the investment case to apply for a financing for a comprehensive GBV-programme to strengthen coordination of the GBV prevention and response system over the coming 6-10 years.
3. Identify opportunities within broader governance, public administration, and ICT reforms to clarify roles, responsibilities, performance expectations for functional and policy coordination, and to leverage new data-platforms for data sharing through: (i) development of a competency-based roles and responsibility framework for professionals across sectors that are involved in GBV-case/functional- and policy coordination; (ii) Review and update performance contracts for relevant sectors and professionals that have gone through recent training.
4. Continue to leverage and upskill existing professionals and coordination platforms to ensure a critical mass of knowledge and core competencies for stakeholders, especially grassroots professionals, responsible for GBV prevention and response through: (i) enrolling as many

individuals as possible in certified trainings; (ii) expanding the certified training programmes to higher cadres and professionals from the education sector; (iii) identify and roll our new certified training programmes to enhance planning capacity, analytical skills, data use and monitoring, communication, management and leadership skills; (iv) facilitate a process to rethink how coordination amongst sectors can “move out of the boardrooms”.

Acronyms

GBV	Gender Based Violence
PMT	Programme Management Team
SDGAA	State Department for Gender and Affirmative Action
IGCF	Inter-governmental Consultative Framework on Gender
ODPP	Office of the Director of the Public Prosecutor
NGEC	National Gender and Equality Commission
DCS	Directorate of Children Services
SRH	Sexual and Reproductive Health
TSC	Teachers Service Commission
CHV	Community Health Volunteer
PRC	Post Rape Care
P3	Police Form No 3 / medical examination report
OB Number	Occurrence Book Number (Police)
CSG	County Steering Group
GSWG	Gender Sector Working Group

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1. Introduction

1.1. Background

The Kenya-Finland Programme on Strengthening Prevention and Response to Gender Based Violence (GBV) in Kenya started in 2022 and is being implemented over 28 months years, ending in December 2024. The programme is designed to reduce GBV and other harmful practices through strengthening capacity of systems and structures at national level and in the counties of Bungoma, Kilifi and Samburu. The programme has targeted moral and legal duty bearers and has worked to increase the engagement of vulnerable groups, support the empowerment of women and youth, mobilize and inspire champions for lasting transformational change in how the system prevents and respond to GBV. The expected outcomes of the programme include:

- Improved capacity of duty bearers to identify, address, monitor and prevent GBV in the targeted counties.
- Improved governance and coordination, policy implementation, strategic planning, and budgeting for GBV at national level and in the targeted counties.
- Adequate and sustainable quality services and systems available in the targeted counties supported by effective national and county strategies and structures.
- Increased levels of engagement of marginalized groups, and champions, to support GBV prevention and response.

The programme office has been hosted within the State Department for Gender and Affirmative Action (SDGAA). A capacity building strategy was developed in 2022. One of its' objectives was to strengthen strategic planning and coordination of efforts in GBV prevention and response. While the Gender Sector has the mandate for coordination on GBV prevention and response, this is a concurrent function that is shared by both the national and county governments in accordance with the Inter-governmental Consultative Framework on Gender (IGCF, 2019). At the same time, coordination of GBV prevention and response efforts, recognizes the critical importance of coordination within key sectors, and coordination across sectors to reduce risk & vulnerability to GBV, and to meet the full needs of survivors and their families in the aftermath of an incident.

During the Inception Phase of the Kenya-Finland Bilateral Programme, the Programme Management Team conducted an e-survey on coordination (Republic of Kenya and Ministry of Foreign Affairs of Finland, 2022a) and began to define and test a framework and tools for coordination. These efforts began with asking: 'what does good coordination look like?' and 'what guidelines and tools have been developed to support good coordination'? In response, stakeholders noted several important dimensions to coordination, including the need to:

- Address the unique drivers of GBV which differ in each county.
- Focus on locations with the greatest risk and vulnerability.
- Proactively plan for anticipated periods of increased GBV, and to leverage opportunities to promote prevention, along with

- Improving systems for networking and information sharing to guide policy implementation.

Consequently, the capacity building strategy of the programme was developed around three strategic pillars for capacity building, namely:

- Strategic planning to enhance coordination amongst stakeholders.
- Development of core competencies and skills for GBV prevention and response, including supportive supervision, reflective sessions, peer-to-peer exchanges, and learning; and
- Support to creating conducive environments for work, including through mentoring, a workplace audit and/or gender audit, low-cost improvements to create a more conducive work environment, professional associations (i.e., GBV first responders), support groups to discuss work stress, "caring for caregivers", professional development opportunities, including "soft skills", such as communication, leadership, and management. (Republic of Kenya and Ministry of Foreign Affairs of Finland, 2023a)

Relying on existing training platforms and targeting a wide range of moral and legal duty bearers in the three counties, the programme supported the enrollment of professionals in the certified training programs for counseling and mediation, as well as the standardized training in community policing (Republic of Kenya and Ministry of Foreign Affairs of Finland, 2023b).

1.2. Objective and purpose

Within a multi-stakeholder GBV prevention and response system, effective coordination is a defining feature of how well the system functions. The objective of the appraisal was therefore to document coordination roles and responsibilities of various cadres with leadership and supervisory roles and professional and volunteer roles in the GBV prevention and response system toinform the understanding of the government and the programme on how the GBV sector is organized for coordination functions within the system.

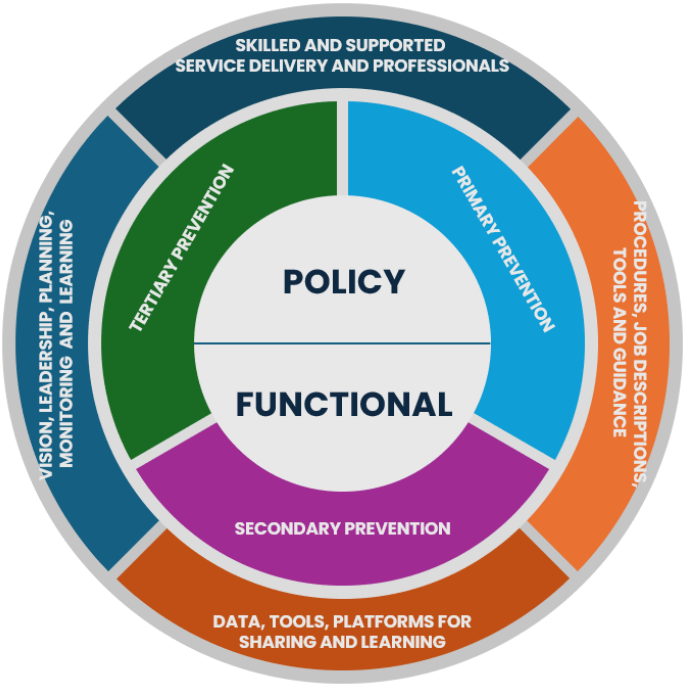
Based on this, it is possible to provide a fresh perspective on the capacity building strategy of the programme and to inform the gender sector on how coordination can be further strengthened to improve the functionality and performance of the GBV prevention and response system in the country. The findings and recommendations can inform future programming in the area of GBV prevention and response, and capacity strengthening initiatives related to coordination.

Conceptual framework

Keeping in mind how the Programme Management Team (PMT) had begun to articulate what good coordination looks like, the appraisal went one step further to guide the data collection and the report findings. In this report, the appraisal of coordination within a multi-sectoral GBV prevention and response system has been organized around two different "types" or purposes of coordination, each one with great importance for the system's functioning and for the outcomes of the system-

response in the lives of GBV survivors. Figure 1 below provides an illustration of how this appraisal conceptualized "coordination", it's different functions and the factors which influence these functions.

FIGURE 1 -FORMS OF COORDINATION



One type of coordination is the functional coordination undertaken by various professionals for prevention and response to cases of GBV. Functional coordination is done in the context of case management that requires professional collaboration and referrals and that may sometimes involve escalation of cases both within sectors (e.g., from one health service to another) and between sectors (e.g., from a health service provider to police service). The extent to which coordination is efficient depends on clarity on sectoral roles, capacity and trust amongst professionals and stakeholders that need to collaborate and coordinate their interventions for a GBV case. It also depends on procedures, where a common understanding of procedures amongst those who are "coordinating" and managing the cases is crucial for the case management process. Functional coordination can be strengthened with training on procedures, professional supervision, performance evaluation, peer support and guidance to further anchor these procedures as part of professional behaviour.

A second type of coordination is policy coordination to inform strategic planning, decisions on targeting of activities and supports, monitoring, evaluation and learning within the system on the efficiency of the prevention and response. Policy coordination requires clarity on this coordination role and purpose, and agreement amongst the various sectors on who the policy-lead is, and which sectors are to be coordinated. It also requires clarity amongst everyone involved on how each sector contributes to a multi-sectoral system, and it requires accountability of everyone involved to undertake their roles and feed the policy-lead with data and information so that this function can efficiently direct the multi-sectoral policy response. Policy coordination can be facilitated by a clear vision, availability of data, tools and skills for data use for planning. It can also be facilitated through common platforms for strategic exchanges, e.g., where common priorities are defined and each sector reports on the activities undertaken to implement common priorities.

In this appraisal the coordination function has been organized around two different purposes:

*(i) **Functional coordination** within and between sectors to manage cases of GBV; and*

*(ii) **Policy coordination** to inform strategic planning, monitoring, evaluation and learning within the system.*

While the gender sector is responsible for coordinating the GBV prevention and response system, the purpose of this coordination role is not defined.

Each of these aspects of coordination depends on competencies and the guidance professionals have to execute the core duties within the respective sector, and across. It also depends on cross-sector working relationships, that those involved have the interpersonal skills, networking, and communication abilities to engage across sectors for effective information sharing, and mobilization.

Coordination is currently defined as a professional task in the job descriptions for the Gender Directors at the State and County level, however there is no distinction made between different types of coordination, namely policy coordination and functional coordination. The interpretation of what the "coordination" function means is therefore left open to the system stakeholders.

2. Methodology

2.1. Scope

The appraisal focused on the GBV prevention and response architecture provided by multiple sectors. While there are many duty bearers who have a mandate to play in a GBV prevention and response system (UN Women and partners, 2019), the appraisal focused on those sectors and organizations that have the primary frontline responsibility for identifying and documenting cases as way of coordinating the prevention and response efforts in GBV prevention and response, namely sectors of:

- Peace and security,
- Health
- Law enforcement: Police
- Justice: Office of the Director of the Public Prosecutor (ODPP)
- Children's services
- Gender, and
- Education.

Data was collected from the three counties targeted by the programme, namely Samburu, Bungoma and Kilifi counties, and the corresponding national-level oversight structures.

2.2. Field work

The appraisal started with a series of national level interviews with stakeholders in February and March 2024. These interviews helped to map stakeholders of various sectors involved in the GBV prevention and response system at national, county levels and below. This mapping helped to identify the stakeholders that were thereafter requested for face-to-face interviews in the three counties during field work. Data collection in the three counties took place as follows:

- Bungoma 18-22 March 2024
- Samburu 26-29 March 2024.
- Kilifi 8-12 April 2024.

As data sources, the appraisal has relied on desk review and key informant interviews, with a total of 87 key informants from gender, health, education, social protection (children's services and social services), peace and security, law enforcement (prosecution and police) sectors. Key informants represent both positions in charge of county policy coordination as well as service implementation at grassroots/front line level. The profile of respondents is summarized in Table 1 below:

TABLE 1 - PROFILE OF RESPONDENTS

Geographic representation	• 5 national level informants, • 30 respondents from Bungoma • 29 respondents from Samburu • 23 respondents from Kilifi
Sectoral representation	• 7 respondents from gender • 28 respondents from health • 13 respondents from education • 2 respondents from social services • 10 children's services • 10 respondents from peace and security • 7 respondents from police • 4 respondents from ODPP • 3 Programme coordination • 3 Civil society
Governance profile	• 5 national level informants • 34 informants from administration at county level • 37 informants from administration at sub-county level • 11 Grassroots / front line service providers

2.3. Assessment questions

Stakeholders involved in interviews were asked questions to help:

- Chart the GBV prevention and response architecture in the three counties to map out the organizations in the sectors of peace and security, health, law enforcement (police and ODPP), children's services, gender and education that have front-line duties and professionals that should be involved in documenting GBV cases.
- Identify the type of activities and initiatives for coordination that are implemented by various sectors.
- Identify what sectors perceive as their biggest contribution to reduce the incidence of GBV.
- Identify professional roles in the documentation and coordination of cases within and between these organizations.

- Chart reporting, supervisory lines and workflows within and between organizations for escalating cases and providing stronger supervision of cases that are documented.
- Identify practices for appraisal, peer support and guidance.
- Identify referral and escalation practices within and between organizations.
- Identify policy planning and coordination practices, including how data is collected and used, including for learning on effectiveness of GBV actions to reduce vulnerability and risk.
- Identify coordination platforms and the professional experience of these.
- Identify priorities and topics for future capacity strengthening efforts to enhance the effectiveness of the GBV prevention and response.

2.4. Limitations

The appraisal was based on a rapid assessment with one week of data collection per county. This means that the testimonies on the roles and functions of each sector is informed from a small sample of stakeholders involved in the coordination and response system. The appraisal provides a qualitative view of functioning, strengths and weaknesses of coordination, not a statistically representative view. Further, the appraisal reviewed the coordination within GBV prevention and response system, along with the approaches implemented by the program to strengthen coordination. However, the program had at the time of the appraisal only been operational for a very short period - a little bit more than a year and a half. The advantages of undertaking the appraisal at this time is that it can shed light on future actions. The downside of the timing is that the efforts supported by the program could not be the core focus of the appraisal. A second report will be prepared to reflect on the capacity building strategy of the program, in the context of the findings of this appraisal.

In Kenya, there exists a wealth of guiding documents, such as policy, guidelines, tools, resource kits for duty bearers involved in the GBV prevention and response system in Kenya. For example, in 2014, Republic of Kenya adopted a National Policy for Prevention and Response to Gender Based Violence that defines the roles and obligations of various stakeholders in the GBV prevention and response system (Republic of Kenya, 2014). In 2017, the National Gender and Equality Commission (NGEC) developed Duty Bearer's Handbook (National Gender Commission, 2017) further detailing the roles and obligations of all duty bearers in the multi-sectoral GBV prevention and response system. In 2019, UN Women and partners, developed a standardized training tool for duty bearers, stakeholders, and rights holders, also targeting the multi-sectoral GBV prevention and response system (UN Women and partners, 2019). Various other duty bearer organizations, such as Police services, Ministry of Health (2018), Ministry of Labour and Social Protection (2019), Office of the Director of the Public Prosecutor (ODPP, 2021), have in addition developed sectoral guidance and standard operating procedures to advance the implementation of duty-bearer roles and obligations in the system. Overall, these guidances and toolkits provide a comprehensive framework for action, however they have not yet been fully rolled out in the country.

The current report is a summary report of findings from all 3 counties as there are features of system functioning that can help inform future actions and strategic directions of policy and capacity building efforts. Each county has a different operating environment, e.g., in terms of population, language, education, and the specificity in the operationalization of nationally prescribed actions, such as for example the platform for coordination, the Gender Sector Working Group (GSWG) in those contexts is not necessarily captured in the present report.

3. Functioning of the GBV prevention and response system.

3.1. Governance and organization

Finding: *Each of the three counties has a functioning multi-sectoral system for GBV prevention and response that could be better leveraged if each sector saw the piece they played in the bigger puzzle.*

Each of the three counties – Bungoma, Kilifi and Samburu - has a functioning multi-sectoral system for GBV prevention and response, that rests with paid professionals who are filling various posts within gender, health, education, social protection (children's services and social services), peace and security, law enforcement (prosecution and police) sectors[1]. The sectors that are involved in the multi-sectoral system has various institutional representation in the form of professionals who operate at county, sub-county, ward and all the way down to the community levels. Functionaries of the county and sub-county administrations, or outposted state representatives at county level carry policy coordination-, strategic oversight- and training functions. Frontline services are provided at all levels – county, sub-county, ward and community with increasing levels of specialization at county level.

[1] It should be noted that not all countries have professional roles for GBV prevention and response defined in various sectors. It is also not a given that if there are posts and roles defined, that these are filled. The above statements in the text therefore testify of a certain maturity of the system.

Finding: *The GBV prevention and response system has reach and representation all the way down to the grassroots level. As the only paid professionals at grassroot level, chiefs are a unique asset in the system that can be leveraged through training at scale.*

Although Kenya is moving in the direction of decentralization, most of the sectors involved in the GBV prevention and response system, with service provision and professionals involved in GBV prevention and response, are still sectors of the central government. Gender and education are two sectors that have functions that are represented and carried out by functionaries appointed by the central government, but operating at county level, and that also have fully decentralized functions with locally recruited functionaries of the county government. In the education sector, responsibilities between central and county government are clearly divided, whereby central government is responsible for compulsory education levels (primary and secondary education), whereas county government is responsible for early childhood development and education, and vocational training. Table 2 summarizes the representation of various sectors involved in the GBV prevention and response system at various levels of governance.

Although there are slight differences between counties in the numbers of professionals at each level, the systems are quite similar across the three counties. As can be seen from Table 2, the multi-sectoral GBV prevention and response system in each of the three counties has reach, representatives and services distributed all the way down to the grass-roots level. For example, community health volunteers and child protection volunteers (CPVs), who are unpaid but trained community members, play an important role in case-identification, reporting and referrals.

The peace and security sector of the central government, namely chiefs and assistant chiefs, together with county government's local representatives that are called village administrators (available in Samburu and Bungoma) are unique in that this is the only paid professionals who operate all the way down at the grassroots level. As such, chiefs, assistant chiefs and village administrators are a unique assets in the GBV prevention and response system since they are the only legal duty bearers represented at the grassroots level.

While there are these grassroots professionals and volunteers represented in the overall organization of

Box 1: Case study – grassroots mainly take a role once cases have occurred.

In one county the team meets with a community health volunteer (CHV) at the primary health care center to which the CHV is attached. The CHV testifies of the fact that there are very few cases of GBV reported from that level, but recognizes that if they were trained, more could be done to activate community health volunteers to undertake early identification of households that need support. They know where these households are, but they do not know what the vulnerability and risk criteria are for GBV (e.g. drug and alcohol abuse in a family, indicators of family dysfunctionality etc.). Nobody has told them what situations the "GBV prevention and response system" want them to act on, besides when a case has already happened. Empowering them to take on a more proactive role would require defining for them, and training them, on the vulnerability and risk criteria that should trigger a referral, before a GBV-case has occurred.

the GBV prevention and response system, they mainly react once cases have occurred. They are not yet empowered to proactively identify high-risk cases and families, report and refer cases for interventions that could prevent GBV-cases.

TABLE 2 - GOVERNANCE OF THE MULTI SECTORAL GBV PREVENTION AND RESPONSE SYSTEM

			Central government & justice sector						
	County government		Ministry of Interior and National Administration		Ministry of Gender, Culture and Heritage	Ministry of Labour and Social Protection		Ministry of Education	Office of the Director of Public Prosecution (ODPP)
Government sectors	Department of Health	Department Gender, Social Services, Youth and Sports (and culture)[2]	Department of interior	National Police service	Directorate for Anti-Gender-Based Violence & Family Protection at the State department gender and affirmative action	Directorate of Children Services (DCS) at the State Department for Social Protection and Senior Citizen Affairs	Directorate of Social Development at the State Department for Social Protection and Senior Citizen Affairs	State Department for Education	Department of County Affairs and Prosecution Services
County – level administration	Preventive and promotive health function	Gender and social services and culture coordination and oversight function	Peace and security function (County Commissioner)	Law enforcement function (County and deputy police commander, chief inspector)	Gender coordination function (Gender Director)	Children's services coordination function	Social development coordination function	Education coordination and oversight function (County Director of Education & County Director of Teacher Service Commission)	Office of ODPP (County prosecutor + staff)
County level service provider	Referral hospital (medical social workers & dedicated GBV facility)					Children's officers			
Sub-county level administration	Sexual and Reproductive Health (SRH) - coordination function (Deputy SRH coordinator)	Gender Officers[3]	Peace and security function (Deputy County Commissioner)	Law enforcement function at Commanding Police Division				Education oversight function (sub-county directors of education & Teachers Service Commission (TSC)	

[22] There are different combinations of the department names in each County, i.e. Samburu also includes Culture.

[3] Some Departments, have other specialized Officers, including Psychologists, or Officers responsible for multiple functions.

Sub-county level service provider	Sub-county hospital			Sub-county police commander + staff of police division		Sub-county children's officers	Sub-county social development officers		Mobile courts
Ward level administration			Peace and security function (Assistant County Commissioner)	Law enforcement function at Officer Commanding station					
Ward service provider	Health centers and dispensaries			Ward Police Commander + staff at commanding station					
Zone administration								Zonal education officers	
Village – volunteers & grassroots professionals	Community health volunteers		Peace and security function (Chiefs)	Law enforcement function at Commanding police posts		Child protection volunteers	Social development committees, social development volunteers, beneficiary welfare committees		
Sub-location grassroots professionals			Peace and security function (Assistant Chiefs)						

3.2. Coordination

In Bungoma, Kilifi and Samburu, the professionals responsible for the two different aspects of coordination – functional coordination and policy coordination - each of which is of great importance to the functioning of the system, are well represented in the management of the system in each of the counties.

Functional coordination of cases is mainly carried out by the health, police, children's services and ODPP sectors. The main objective is to provide services and healing to victims and to bring cases to court. In this type of functional coordination with a purpose of managing GBV cases, the actors involved in GBV prevention and response systems in the three counties seem to be fairly clear about sectoral roles and the need for coordination and collaboration in resolving cases. However, they are less clear about functional coordination in preventing cases.

For the second type of coordination, which is more related to policy coordination, it does not yet seem entirely clear to stakeholders in the system that policy coordination has a unique and distinct value in driving the effectiveness of the GBV prevention and response system. While functional coordination is guided by a variety of guidelines, tools and SOPs, this is not the case for policy coordination. There are no equivalent guidelines, tools and forms that set out the duties, actions and deadlines to be fulfilled by the various duty bearers and actors in the multi-sectoral GBV prevention and response system in order for the policy lead to fulfill its role. For example, there is no guidance on policy-relevant indicators, e.g. indicator definitions for the indicators to be collected to monitor the policy, forms and guidelines for data submission, timelines or guidance on the monitoring, review and learning process of the policy, when to set cross-sectoral priorities, how and when they should be monitored and reviewed, and what learning can be expected. The practical implementation of cross-sectoral policy coordination is not yet fully described and guided and therefore accountability is limited..

It should also be noted that with so many different sectors and actors involved in the GBV prevention and response system in the three districts, the organization of the system is very complex. There is a mix of national delegated functions and decentralized functions and . Therefore, the system is yet to settle on an optimal organization and coordination, which is the mandate of the gender sector, is therefore a challenge. The findings on the various aspects of coordination are presented in the following sections.

4. Functional coordination, referrals, and escalation of cases

4.1. Sectoral roles

Most intersectoral coordination takes place at the point of documentation and treatment of a case, which is the biggest contribution of law enforcement (police), health sectors and children's services sectors that must intervene once cases are reported to their services. GBV cases are usually reported either at a police station or a health center and are thereafter referred between these service-points as required in the documentation of cases in the Police Form No 3 (P3) reporting and case documentation-form. The following quote describes the typical reporting and referral pathways:

> *"A typical referral pathway of a GBV case can be self-referral, by a family member, a community health worker, police or by a chief to a health facility (...) The survivor then goes to health facility where given services, then survivor is referred to police station gender desk to report the incident, then is given an occurrence number (OB number). From the police, the survivor will be given a police report to take to health facility to fill out. After filling out the form at the health facility it is taken back to the police. When police receive the report, they can undertake arrest. Then the case is assigned to an investigating officer that opens a file (...) then the case can go to court (...). Level of injuries need to be documented, and perpetrator to be identified. Time is often wasted in between each step."* (Respondent from Bungoma County)

The main purpose of intersectoral coordination for case management is two-fold, namely, to ensure that victims get treatment, be that medical and psychological, and to ensure that events are described and documented, and evidence identified and collected to help victims/survivors seek justice. In the case of children, children's services are involved to ensure that children are protected from further abuse.

In the three counties, multi-sectoral coordination of cases (case management) seems to be driven by the referrals required to fill in the P3 and Post Rape Care (PRC) forms (Annexes 2 and 3). This form is the "glue" that ties together the police, health, and justice system in the documentation of cases with the purpose of bringing cases to justice. Occasionally, children's services are brought into the picture if a case of child protection (GBV against a minor) necessitates a placement of a child. Then children's services facilitate that process.

Finding: *Inter-sectoral coordination is the clearest and most predictable between the sectors (health and police) that are tied together through the case documentation by the P3 and PRC forms.*

Social services, education, peace, and security -sectors are also involved, each sector as per their mandate, in the GBV prevention and response system. However, they act more as allied sectors, and are not integrated in the case management system responsible for victims' care, protection, and

justice, required by the P3 form. There is no similar form to the P3 form, that ties together sectors for the prevention and early identification of risk cases, or for GBV cases that might be identified in the education sector, such as for example cases of teen-age pregnancy. Table 3 summarizes the biggest contribution of each sector in GBV prevention and response.

TABLE 3 - BIGGEST CONTRIBUTION OF EACH SECTOR IN GBV PREVENTION AND RESPONSE

Prevention targeting vulnerable communities, families and children	Identification of cases and referrals	Documentation of cases	Emergency response through service provision (treatment, testing, arrests)	Protection (placements of children) and prosecution
Social services	Peace and security	Health (PRC form) Children's services	Health	Children's services
Education	Education	Police (P3 form)	Police	ODPP

4.2. Specialization

The first responders – namely the police and the health sector – of the multi-sectoral system for GBV prevention and response, in the three counties have reached a level of maturity where these sectors have specialized officers and professionals dedicated to preventing and responding to GBV. This specialization is mainly present at the county and sub-county levels. At the levels below, i.e. at ward and community level, professional roles are generic in nature but still have the potential to be used for GBV prevention and response if sufficient numbers of professionals in these sectors are adequately trained, mentored and guided. Interviewees from a couple of the counties indicated that the quality of case documentation, such as in P3 forms, witness follow-up, witness statement documentation, and reporting of laboratory results, varies among cases reported and managed at county level. The quality of case documentation appears to differ significantly between the GBV Recovery Center (GBVRC) of a referral hospital, and cases reported

Finding: *To ensure the quality outcomes of case management for GBV survivors, professionals and frontline service providers from sub-county level and below need to receive more training on how to document cases and collect evidence for cases to hold up in court.*

and managed at lower levels at sub-county or ward levels. Inconsistencies and errors in case documentation have a negative impact on the chances of cases getting justice, because case documentation serves as evidence in court. Additional training of professionals at the sub-county professionals, especially from the police and health sector, to coordinate and document cases seems important.

4.3. Referral and escalation of cases

Each sector, such as education, which may be confronted with cases of teenage pregnancy, or the police and health services, which receive referrals of cases to their service points for treatment or reporting, has its own procedures for handling the cases. Based on the responses and descriptions of professionals from different sectors in each of the three counties, case management within the own sector appears to be sufficiently clear. For example, in one referral hospital, interviewees described how a GBV case reporting to the hospital is guided on where to go to have the service fees waived, where to go for medical examination, and where to deposit samples for laboratory tests. When services are provided "under one roof", such as in the case of a referral hospital, coordination, collaboration and referral between different services and professionals within the hospital seems to work well and in accordance with the procedures established for that facility. However, even when the services needed by a GBV survivor are provided in the same facility, it can be cumbersome and painful for a person who is not in good physical or mental health to access the various services as the logistics around the services are not facilitated. For example, after a medical examination, it is up to the GBV survivor to bring samples to the laboratory (within the hospital), where the survivor may have to wait in line for their turn to turn in the samples or have the additional testing required.

While there is a good understanding between the health, police and children's services sectors of "what can be expected" from the coordination of cases from other sectors involved, and there is a known referral and reporting system enshrined in the PCR and P3 forms (health to police - police to health), the process of case documentation can be arduous and lengthy for survivors of GBV. Completing the case documentation for the P3 form can take a whole day, sometimes longer. Several interviewees also stated that service facilities often lack necessary items. For example, GBV survivors may need clothing, sanitary napkins, hygiene items and food. This type of support is rarely available, and survivors must often purchase these items with their own funds. Also, the P3 form is not always available in paper form, and if it is not, the GBV survivor must first go to an internet café to have it printed out before the case documentation can begin.

> ***Finding:*** *Survivor centered case coordination reduces the risk that cases drop out during the case documentation process. To be more survivor centered, case coordination and case management needs to be facilitated with support to the logistical procedures of documenting the case, provision of necessities to survivors, food and even transport.*

The fact that frontline sectors responsible for case coordination, management and referral remain severely under-resourced, and that case management, coordination and referral are not greatly facilitated, either through the provision of supplies or the management of logistics associated with accessing services, often results in GBV cases dropping out of the case documentation process. Survivor-centered case coordination, supported by the provision of supplies and logistics, appears to be necessary to ensure that GBV case-management is not terminated prematurely. This is also crucial in ensuring that cases are brought to justice. Ensuring that GBV cases are brought to justice is also important for the prevention of GBV, as impunity tends to perpetuate the problem.

In addition to the health and police sectors documenting and referring cases as part of the case documentation required by the P3 referral form, other sectors such as peace and security, education and social development also play a very important role in GBV prevention and responding to GBV. However, these sectors tend to operate on the margins, isolated from the service provision linked by the P3 form. The role of the peace and security, education and social services sectors in prevention and initial response could be further strengthened if these sectors had a clear role as part of the multi-sectoral system to prevent and respond to GBV, and if they had clear criteria for cases that require multi-sectoral coordination, and potentially also a common form to document and refer cases beyond their own sector. In the absence of a clear referral form, like the P3 form linking health and police agencies, the role of these sectors, important as it may be, appears to be underestimated and not properly appreciated by sectors other than their own. Box 2 describes the important role of the education sector, which can be further leveraged by other actors in the cross-sectoral system.

Box 2: Role and actions of the education sector in GBV prevention and response

The Education Gender Policy 2015 is currently being revised and is expected to be finalized by end 2024. GBV will be well defined for the education sector in this updated policy. Education has rolled out several activities on GBV prevention, e.g., in the PRIDE-project, in training of teachers and in sensitization of field officers. In addition, GBV is part of the main courses on HIV. There is a school re-entry guideline allowing girls under 18 who have gone through teenage pregnancy, to re-enter school, to ensure that learners not only are in a protective environment, free from GBV, but also that education is a social support system for students who have suffered GBV in their community or elsewhere.

Criteria for escalation of cases and the pathways for referral to agencies/officials with greater specialization and training in GBV do not appear to be entirely clear in any of the sectors involved in GBV prevention and response. Since escalation of cases can help ensure accountability for better outcomes for cases, this is a factor that limits the quality of the services received by the survivor. The exception is cases referred from county level to the national levels, where the criteria for referral appear to be clear enough. However, at the county level and below, who gets to treat the case seems to depend more on which level the case is reported to, e.g. at a primary health center or at a referral hospital, or at a grassroots police station or a county police GBV service, rather than the complexity of the case and where in the system the capacity to respond is the best.

4.4. Clarity on roles, capacity, and trust

Functional coordination of cases depends on the extent to which there is clarity about sectoral roles, capacity and trust between professionals and stakeholders who need to collaborate and coordinate on cases. It also depends on established procedures and understanding of procedures among those who 'coordinate' and manage cases.

In the three counties, the sectors that make up the multi-sectoral GBV prevention and response system and that were interviewed as part of this assessment, namely education, social development, peace and security, health, police, children's services and ODPP, do not yet appear to have a fully clear and shared vision of how the different sectors can work together and coordinate to reduce the number of GBV cases while ensuring that survivors experience justice and healing. For example, the education system and social development sectors could play a very important role in the early identification of risk, whether among students or in communities, as these sectors come into contact with community members, parents and children through their services and programmes before GBV cases occur. However, the education system appears to be relatively isolated from the other parts of the multisectoral system.

While respondents from the education system describe their role in identifying cases of GBV (e.g. cases of defilement and teenage pregnancy) and how they facilitate that these children continue to benefit from education, e.g., after the birth of the child, the education system also has wider potential for early identification of children at risk and referral to prevention services in other sectors. As far as this assessment could document, however, this role is not being played by the education sector, nor is this potential being exploited by other sectors, even though professionals recognize the important role of the education sector in this context. One interviewee (not from the education sector) reflected the desire to associate the education sector more closely to the GBV prevention and response system with the following words:

> *"If we can also single out Ministry of Education and parents and design a programme that builds capacity of teachers, parents and teachers association and schools and reach out to them and also the students and the pupils, that would be good." (*Respondent from Bungoma)

Similarly, the Department of Social Development runs social protection programs and provides targeted support to families and communities, but this targeting is not based on the knowledge that the gender sector, health, police, education and children's services have gathered about cases and incidents of violence against women. Nor are social services required to report on GBV risks that they may observe during their community or household outreach.

However, professionals in different sectors, each with their own perspective, recognize the uniqueness of their colleagues in other sectors that could be better utilized. For example, in one

county, a respondent from another sector reflected on the importance of chiefs from the peace and security sector as first responders in GBV cases:

> *"When we were finishing up the counselling course, the chiefs were giving back the feedback and how they were able to handle cases. This is the first place where cases are referred to!"* (Training beneficiary from Samburu County)

At the same time, the "uptake" of this important role by chiefs and the peace and security sector differs both between counties, and possibly also within counties, depending on whether chiefs have been made aware of their unique and important role in identifying and responding to cases of GBV. In Kilifi, a respondent reflected on the following situation:

> *"Officers (chiefs) have not internalized that GBV is an issue of security at the grassroots level. They are thinking about other security issues and think that wife-beating and teenage pregnancy is part of the culture and that this is something that teachers need to work on. But commissioners' staff are thinking about who is selling drugs on the street. In their natural mindsets they are not so much about social issues.* (Respondent from Kilifi County)

Table 3 provides some examples of the unique characteristics of each sector that can be further disseminated and utilized within the system to strengthen role-taking and a coordinated response to GBV cases. Unique characteristics that can be further documented, disseminated and utilized within the multi-sectoral system are color-coded with pink color in the table, while the unique roles and characteristics marked in green are already fairly well understood and utilized.

TABLE 3 - UNIQUE ROLES TO LEVERAGE IN A GBV PREVENTION AND RESPONSE SYSTEM

	PREVENTION			**RESPONSE**			
	Peace and security	**Education**	**Social development**	**Health**	**Police**	**Children services**	**ODPP**
Unique features to be leveraged	Can serve as a door-opener to communities, can help strengthen trust in other service providers that are not as near.	Access to all and uniquely positioned to enforce messages around self-protection, reduce vulnerability and risk.	Comes into contact with vulnerable households and communities and therefore well placed to help identify	The unique place in treatment and providing healing to victims is recognized	The unique place in investigation and collaboration with ODPP to bring cases to justice is recognized	Provides care and protection to children who cannot continue stay in their immediate care environment.	The unique place in bringing cases to justice is recognized

In that context, and on the importance of leveraging grassroots professionals and volunteers further, one respondent expressed the following:

> *"For long, I have the view that let us reach out to the communities. We cannot talk about GBV at boardroom level and duty bearers, but we need to find a way to build capacity of the community. We need a programme that can build capacity of the community members. That would be an advantage."* (Respondent from Bungoma County)

However, the unique position of chiefs from the peace and security sector, for example, is sometimes underestimated. In two different counties, a couple of respondents reported incidents that evidenced a sense that one sector was overstepping its mandate and the boundaries of what is seen as the role of another sector. This created tensions between professionals from the two different sectors. Such rivalries and tensions between sectors can arise when the delineation of roles and functions is not clear enough. They are counterproductive to fluid coordination around case management but can be overcome when the goals of the overall multisectoral GBV prevention and response system are more clearly defined and when each sector has self-awareness of their own and others' role, strengths and weaknesses. When such clarity emerges, the importance of collaborative coordination in case management will also become clearer.

If there were reportedly some rivalry and tension between sectors and professionals, at least in a couple of the counties, several interviewees also indicated that the training programmes (particularly the counselling training offered under the Kenya-Finland bi-lateral programme) can and do increase trust between professionals from various sectors. Several respondents indicated that the programme has not only improved their understanding of the role of other sectors but has also changed the way they interact with other professionals in their own workplace. As a positive example of the improvement in this self-awareness thanks to the training, one respondent commented as follows:

> *"They have strengthened duty bearers a lot with different courses – they have skills now (...) I benefited to from the counselling psychology. In my workplace, how I am responding to my colleagues is different now. I have a different perspective now."* (Training beneficiary from Samburu County)

4.5. Professional supervision, peer support and guidance

Professional supervision, peer support and guidance are factors that can influence good case coordination and improve professional clarity of roles, coach supervisees and peers on procedures and provide guidance so that trust can grow between professionals within and between sectors. Performance evaluation is a tool and process that can be used to formalize, regularize and institutionalize professional supervision. The appraisal explored how professional supervision, peer

support and guidance are currently delivered and offered within the system to further contextualize the potential impact or limitations of the program's capacity building strategy.

In each of the sectors involved in the GBV prevention and response system, there are clear professional positions with leadership, supervisor and supervisees roles. There is also a clear supervisory culture in each sector. Respondents could clearly describe their reporting lines and how they are taking direction within their own sector. However, the nature of the supervisory culture varies from sector to sector. For example, in some sectors a hierarchical system of supervision with clear 'supervisor' and 'subordinate' roles is prevalent, while in other sectors, alongside the formal hierarchy, there is also organized professional supervision with 'supervisor' 'supervisee' roles, sometimes without formal reporting lines between them.

A hierarchical system of supervision with clear “superior” – “subordinate” roles and reporting lines between them seems to be the predominant organizational model in the peace and security, police and education sectors. In these hierarchical systems, supervision is expressed through upward reporting and top-down instructions. Coaching, support and professional supervisory processes aimed at professional development are less important. Examples of hierarchical supervision are:

- The teacher service commission within the education-system, that plays a very important role in teacher supervision, planning, performance evaluation, and sanctioning of teachers (if needed).
- The rank-system at duty stations within the police sector, that defines the hierarchical relationships, authority and responsibility, and the supervision culture within the police service.
- The vertical upward hierarchical reporting system within the peace and security-sector that is underpinned by a hierarchical relationship between assistant chiefs – chiefs- deputy commissioners and commissioners, with clear lines of command and subordination, reporting and communication between each level of governance.

Within these sectors, supervisors and supervisees may be working in the same office or duty station (e.g., which is often the case in police), or in different offices at different levels of governance (e.g. in education and peace and security).

While a hierarchy is also present in health, children services and social services sectors, these sectors seem to have more of a blended supervision culture with stronger elements of organizational professional supervision than in the above-mentioned sectors. The

***Finding**: Within each sector there are clear professional positions with leadership, supervisor and supervisees roles and there is also a clear supervision culture in every sector. However, the supervision culture varies, and, in some sectors, it is more hierarchical while in other the hierarchy is blended with a culture of professional supervision.*

professional supervision, that co-exists within the hierarchical culture is expressed through for example meetings or performance appraisals where "supervisors" provide guidance, support and sometimes fulfill a role of trainers to their "supervisees" or other professionals in the system. For example:

- Health has a hierarchical organization within service units (hospital, health care center) but the health administration at county level plays an important role in training, guidance and couching of professionals and service providers.
- Children's services and social services has a hierarchical reporting system from county to national level, but there also seems to be elements of professional guidance and supervision of child protection volunteers and children's services officers.

Training and digitalization seem to be contributing to a (still ongoing) change in supervisory culture. In children's services, for example, there is a management information system that tracks caseloads and provides the ability to view dashboards, and professional performance. There is a reward system for work well done.

Several interviewees stated that the training organized in the Kenya-Finland bi-lateral program showed "new" ways of interaction between professionals, indicating a change in the supervisory culture in the systems driven by the professionals who participated in the trainings. The following quote illustrates how one respondent reflected on the supervision culture within the system prior to training:

> *"The supervision system is very weak. I don't know if it exists even. You must have objectives for supervision, you must have some action points with timelines, and you must have follow-up on these points. I have not seen any supervision done in the system like this (...)"* (Respondent from Bungoma County)

However, organisational cultures do not change overnight. And for a supervision culture to emerge in which formal or informal supervisors and peers can coach each other and facilitate a professional response to cases, there seems to be an intermediate step that needs to be nurtured further, and in which the programme has planted a seed that needs to continue to grow. The following quote from training participant feedback illustrates how one training participant reflected on the importance of being able to manage one's own emotions first in order to be a good supervisor for others:

> *"People have said they are empowered. They have been fatigued after hearing so many terrible stories in their daily work. (Now after training) they have gotten rid of their things that were holding them (...In their work) they wanted to be counsellors but have not had counseling themselves. It (the training) has also fostered working together."* (Respondent from Kilifi County)

5. Policy coordination in the context of strategic planning

The assessment documents on one hand the coordination that has the purpose of case management. This is a function in which the gender sector does not play an important role (or any role at all) because it does not have frontline professionals responsible for documenting cases Their mission has not been described to include this case management service. However, the gender sector can play an important role in the the coordination function which is more for policy coordination that was also captured, but in the second part of this report.

Policy coordination is important to underpin strategic planning, to inform decisions on the targeting of activities and support interventions, and to support monitoring, evaluation and learning within the system on the effectiveness of prevention and response.

Like functional coordination in the management of individual cases, policy coordination requires clarity on the role and purpose of coordination and agreement between the different sectors on who has the policy lead and which sectors should be coordinated. In addition, all stakeholders need to be clear about how each sector contributes to a multi-sectoral system, and all stakeholders need to be responsible for providing the sector accountable for policy leadership with data and information to carry out this function effectively.

Without a clear vision of what the policy and system are supposed to achieve, policy coordination can be difficult. Furthermore, policy coordination works poorly without data, tools and capabilities for data use and planning. Therefore, policy coordination is facilitated by a clear policy vision of all actors involved, clarity on roles in the system, availability of data, tools and capabilities to analyse and use data for strategic planning, monitoring, evaluation and learning. It can also be facilitated by common platforms for strategic exchange, e.g. when common priorities are identified and each sector reports on the activities undertaken to implement the common priorities.

5.1. Vision

One of the challenges faced by the gender sector in implementing its policy coordination role is probably the fact that there is not yet a clear and shared vision of the multi-sectoral GBV prevention and response system and how this system can and should act together to respond to cases and ensure sufficient and appropriate service provision. One interviewee formulated the challenge as follows:

> *"Do people have a common understanding of the system? Not really. Just a few months ago we had all departments together and they were told their role. Then the blame game started."* (Respondent from Samburu County)

The vision, even if expressed on paper, seems to be hazed by an absence of a clear commitment to the issue, a driving force and leadership from highest instances, that places GBV front and center

as a development issue of the country, with a clear understanding of the cost to society, if not addressed.

> *"Our capacity and functioning (as a GBV sector) are at 40%. It's the same, same pulpits: culture, lack of goodwill, not a unified front of fighting GBV (...) There is so much work still to be done (...) State and county need to be serious about GBV – now they are hazy. GBV is everywhere, in churches, workplaces (...) The governments – state and county - have not been able to quantify the losses of not preventing GBV, and not quantified the gains we could make if GBV was prevented (...) Without GBV, this child could have been an engineer... a teenager gets pregnant, drops out of school (...) There is a lot of loss of potential."* (Respondent from Kilifi County)

5.2. Roles, capacity and tools

Furthermore, while the gender sector plays an important role in policy coordination in the context of strategic planning, this function appears to be difficult to implement for various reasons. For example, there seems to be a lack of clarity about the differences between functional and policy coordination and the fact that these are two different coordination functions that need to be present in the system, but which are performed by different sectors that need to support and cross-fertilize each other for the overall system to function well.

While policy coordination can be facilitated by the availability of data, knowledge, tools and skills to use data for strategic planning, the gender sector does not currently 'own' the data on cases, and there is no obligation and no enforced procedure for sharing data from other sectors with the gender sector. The problem of data is related to the fact that GBV is a stigmatized issue and far from all cases are reported, leading to an underestimation of the importance of this issue for the country. In addition, the data often remains within the sector in which it is reported and the protocols for data sharing are not in place, as described by this interviewee:

> *"When it comes to reporting, not all cases of GBV are captured (...) we only capture the data we can access (...) How I wish we had one reporting system, some kind of coordinated (data) system."* (Respondent from Bungoma County)

5.3. Tools for data collection, storage and sharing

Nonetheless, and despite the described challenge related to data and data sharing to inform and evaluate whether the vision of the system is being achieved, each sector involved in the GBV prevention and response system collects, stores, reports and uses data in its own area to inform and

evaluate its interventions. However, the culture of data sharing is still heavily influenced by hierarchical systems and most data flows upwards as part of regular sectoral reporting requirements. Less use is made of data for programmatic monitoring and performance evaluation. Organizational learning does not yet appear to have permeated organizational cultures in any sector, but several sectors have begun to implement electronic management information systems that allow for the visualization and use of data at all levels (as exemplified by the Department of Social Services in Bungoma and the Department of Children's Services in Kilifi). This modernization reform holds great potential for integration of data systems and data sharing, as well as for more regular use of data at all levels for strategic planning, policy monitoring and evaluation, which could be facilitated by the gender sector.

In this context, it will be helpful to select from the National Monitoring and Evaluation Framework for the national GBV-policy (Republic of Kenya and The National Gender and Equality Commission, 2022) and agree on a few strategic policy relevant indicators that would help the gender sector to play its policy coordination role in full. Data on these indicators should thereafter be reported directly to the gender departments at county and state levels.

5.4. Tools for planning and prioritization

Prior to the start of the programme, none of the counties seems to have had tools for planning and prioritization of activities and services. The planning tools – a seasonal calendar that identifies high-risk events and times of the years, as well as a geographic map indicating hotspot areas - introduced by the Kenya-Finland bilateral programme on GBV prevention and response with a view to strengthen the coordination role of the gender sector, are therefore referred to as something of an innovation:

> *"The approach of this programme has been unique when it comes to targeting and using the tools to map out the high-risk zones. It has been driven by communities themselves. Communities know their problems, so these tools were harvesting this knowledge. Existing data was used to inform decisions…The other department have realized that this is the way to go. We should not just implement blindly."* (Respondent from Bungoma County)

One of the innovations seems to have been how the data was collected from the grassroots, a method that overcomes the deficiencies of the system reported above, namely that cases are not always reported and therefore makes data incomplete. Another innovation seems to have been how these tools were co-created and how this contributed to ownership:

> *"We co-created that tool, we did not just give input. We were able to pin down, where and what the drivers are of GBV and what enhances the vulnerability. So, we came up with a very strategic tool, which in my view is the starting point of addressing GBV in community context. We are able now to contextualize the response"* (Respondent from Kilifi County)

The gender departments in all three counties seem to have a good understanding of the drivers of GBV in their counties and report that they have made use of the data compiled in the tools and have informed various activities for GBV prevention and response, as a result.

> *"Risk analysis tools and a calendar was done through a consultative process to map out the hotspots (...) sub-counties and wards were identified. Color coding was done. Our focus was on red zones. We had 5 red sub-counties and 22 wards where we have focused our implementation. In our calendar we have seasonal variations when we expect higher incidence of GBV. We identified the factors that contribute to higher incidents (...) There is a lot of indulgence and so during Christmas and then defilement and rape due to festivities (...) When there is school closure (...) pregnancies increase during such time. During harvest, when they have money in the pocket, they have leisure activities and schoolgirls are given gifts and then they are defiled (...)* (Respondent from Bungoma County)

During project implementation, specific activities were apparently also planned in sensitive periods, targeting vulnerable geographical areas with prevention measures. In Samburu, the planning calendar is now part of an information package of the county for new staff/actors who want to work in the area of GBV. In Bungoma, the calendar and vulnerability map are prominently displayed on the wall of the national gender department office.

However, the introduction and use of these planning tools has not been sufficient to promote the emergence of a strategic planning and learning culture in the gender sector in general in all districts. For example, the original mapping exercise has not been updated, nor is there yet any evidence of changes in planning practices and the culture of the gender sector in general. It is perhaps too early to expect such impacts, as this interviewee said:

> *"The Calendars and risk analysis – tools – this was developed quite recently about 8 months ago. It was used to develop activities of the programme. We used it to decide where to train people first and when. We haven't updated it, but we are just following it "*(Responded from Bungoma County)

But it is also likely that the introduction of these tools is not enough and that more stimuli are needed for a change in the planning and learning culture of gender departments to emerge.

5.5. Mechanisms / platforms for coordination

Policy coordination and strategic planning can be facilitated through common mechanisms and platforms for strategic exchanges and by defining common priorities and acting on them. In each of the counties, there are multiple coordination platforms operating in paralell, for example there is the:

- Gender technical working group (also exists at sub-county level)
- Health technical working group (also exists at sub-county level)
- Court users committee
- County Steering Group (CSG) for emergencies
- Anti-FGM board
- Department heads meetings (internal)
- Social risk management committee (Kilifi and Bungoma)
- County Children Advisory Council
- Area Advisory Councils

The Gender Technical Working Group is referred to as functioning well and as being vibrant also at sub-county level in at least one county (Bungoma). In one county, the functioning of the GSWG is described like this.,

> *"The Gender Sector Working Group is the main platform where we meet. There are quarterly meetings but sometimes we meet more often when there is a need. This could be for example is a new partner is coming on-board and it cannot wait then we convene more often. If there is a specific training, we may convene more often (...) We also discuss cases that have stalled (...) If a case is stuck at police or ODPP level, it is easier to discuss it at the forum."* (Respondent from Samburu County)

However, the effective functioning of these coordination platforms is often dependent on donor funding and some sectors are not part of the GTWG yet, such as ODPP, in the case of Bungoma, and Education in the case of Samburu.

A challenge for the effective functioning of any of these coordination platforms, furthermore, is reported to be linked to the fact that participation is not consistent. Some sectors tend to send different people each time. In at least one county, effective function is also limited by the very junior participation in meetings, which leads to a lack of decision-making power in the coordination platform.

Effectiveness can also reportedly be strengthened by a better practice of taking minutes, sharing meeting minutes, defining action points after each meeting, and reporting on the following up on action points in the next meeting. This kind of meeting culture is not yet fully absorbed. This seems to be a challenge in all Counties. One respondent put it like this:

> *"Under the coordination of Gender Sector Working group, we need to capture minutes and have a file for our minutes. There is often nothing to refer to. The GSWG meets when there are resources. At times we have a good number of partners supporting then we meet almost every month but when not... we meet every three months as before. They need to communicate the agenda and action points early. No joint workplan exists just collaboration and it is not well structured to address problems ... there is a need for activities to follow up*

discussions beyond the meetings in boardrooms. The meetings depend on what we will be discussing..., if there is an international day, there might be a workplan e.g. the calendar of events. We often lose track of what was supposed to take place." (Respondent from Bungoma County)

6. Conclusions

This assessment of GBV prevention and response system coordination in three counties in Kenya documents and describes two distinctly different coordination functions required for a well-functioning GBV prevention and response system. One coordination function is functional coordination, which is both an inter-sectoral and intra-sectoral case management process that responds to and coordinates cases of GBV involving different sectors and professionals at different levels, mainly at the county level and below.

The appraisal documented two distinctly different coordination functions – functional coordination for case management and policy coordination to inform planning, targeting and learning.

The goal of functional coordination is to support survivors to heal and get justice. The other coordination function is policy coordination, which relies on a very different process but requires collaboration between the sectors involved in functional coordination in sharing data, participate in joint planning, visioning, prioritizing, monitoring, reviewing progress, and in facilitating cross-sectoral learning about what works and what does not work. The ultimate purpose of policy coordination is to ensure that policies, programs and interventions can be progressively developed and strengthened to improve outcomes for survivors and reduce the number of GBV cases in society. To achieve this, policy coordination, planning and learning processes need to be informed by service delivery outcomes for survivors. Thus, in needs to be informed from data on the outcomes of functional coordination and case management.

In Kenya, the functional coordination role has been well described in a variety of sectoral and inter-sectoral manuals, handbooks, procedures, guidelines and tools. These outline the roles and for functional coordination to be undertaken by both the individual sectors and their frontline professionals. There are also examples of manuals and tools that describe functional coordination as an inter-sectoral process to be undertaken in collaboration between sectors. In practice, functional coordination is tangible and implemented within many sectors. However, as described by actors working in the system, prevention and response efforts still appear to be separate and distinct actions to implemented within each sector, rather than a multi-sectoral coordinated process. Multi-sectoral functional coordination, as described in manuals and guidelines, is yet to be fully embraced by relevant actors.

One exception is the cross-sectoral functional coordination that is evident in the way case management is carried out by police, health and ODPP to bring cases to court. This cross-sectoral

Functional coordination is guided by a multitude of tools and manuals that have not yet been fully rolled out. In comparison, policy coordination is much less guided, and the equivalent number of manuals and tools are not available.

functional coordination is facilitated by the documentation of evidence reported in the P3 and PRC forms. Such cross-sectoral functional coordination of cases focuses more on response once a GBV offense has occurred. There is no equivalent multi-sectoral case management coordination, facilitated by a coordination tool, similar to the P3 form, that focuses on prevention, early identification and referral of high-risk cases (before a breach has occurred).

Compared to functional coordination, policy coordination is a task that appears to be much less directed. There are not the same number of manuals, handbooks, procedures, guidelines, tools and forms for implementing policy coordination in practice. The National Monitoring and Evaluation Framework that was developed to accompany the National Policy on Prevention of and Response to Gender Based Violence in Kenya has not been adapted and piloted in the three counties. In both functional and policy coordination, coordination is a challenge due to the large number of actors and sectors that are involved. Stakeholders from all sectors interviewed for this appraisal expressed a desire for better coordination and clearer organization to better respond to and prevent GBV.

The actors in the three counties seem clear about their sectoral roles and the need for coordination and collaboration in resolving cases but less clear on functional coordination in preventing cases.

Both policy and functional coordination are shaped in the context of broader government sector reforms, including a devolution process that is redefining responsibilities for policy planning, priority setting and monitoring. Furthermore, an ongoing reform of the public administration is modernizing performance appraisal processes and introducing information and communication technology (ICT) as a new modern platform for management information systems to replace paper-based record keeping. However, the progress in not equal across sectors. Some sectors are more advanced than other in this reform.

Functional and policy coordination are taking place and are shaped by broader governance and public administration reforms, including decentralization, public administration reform and modernization reforms linked to the introduction and use of ICT. Expecting rapid improvements in coordination in such context is unrealistic.

While these reforms, that are visibly taking place in several sectors, can facilitate improvements in policy coordination practices, they are likely to take many years to conclude. Expecting rapid improvements in coordination and a well-organized system in such context would be unrealistic. In this context, strengthening system stakeholders core competencies to create a common baseline of knowledge and skills that makes GBV prevention and response activities more predictable to all

involved is a strategic choice. Going forward, programmes aiming to support coordination for GBV prevention and response could usefully tune in and synchronize activities with these broader governance, public sector and ICT reforms to facilitate their adaptation and implementation in the GBV multi-sectoral system.

7. Recommendations

Based on this assessment, going forward, the following recommendations are made to strengthen functional and policy coordination of the GBV prevention and response system in the three counties:

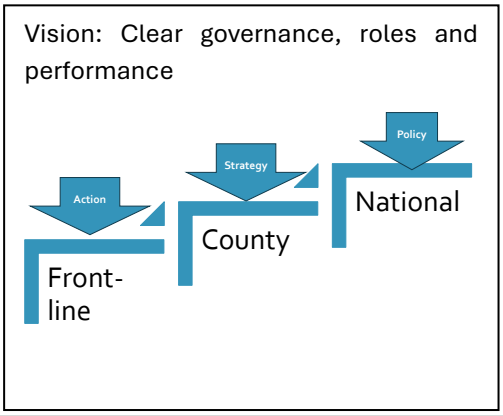
Recommendation 1: Advancing a dialogue across the GBV sector to define coordination according to a new conceptualization, i.e. policy and functional coordination, and facilitate a better understanding on how the different professional roles in the multi sectoral system complement each other in the response, and also in coordination.

Recommendation 2: Develop a common understanding among sectors and practitioners of the goals and vision of a well-functioning GBV prevention and response system and use the National Monitoring and Evaluation Framework towards the Prevention of and Response to Gender-Based Violence in Kenya for measurement of the performance of the system.

Recommendation 3: Activate grassroot volunteers, professionals, social development and education as agents to drive prevention, early identification and referral of high-risk cases (before a breach has occurred) through developing clear criteria for case identification and a coordination tool in the form of a reporting and referral form, similar to the P3 form that can help link the different sectors in the preventive and early response to risk.

Recommendation 4: Define elements of coordination that require further capacity strengthening, agree on core competencies needed across all sectors, and ensure the necessary budgetary investments for a capacity development agenda that can upskill professionals with supervision and accountability to ensure the workforce can/does apply these new practice.

Recommendation 5: Develop a competency-based roles and responsibility framework for professionals across sectors that are involved in GBV-case/functional- and policy coordination. The framework should reflect supervisor and supervisee roles, governance and can later be used to review/update job-descriptions of professionals at various levels, in various roles and sectors.



Recommendation 6: Review and update performance contracts for relevant sectors and professionals that have gone through recent training to make sure these performance contracts reflect expectations on newly trained professionals, including obligation of supervisory to regularly meet with direct reports, to conduct case reviews to ensure timely responses to reported cases, documentation of actions, referrals and services provided to survivors, as well as gaps in the response (Republic of Kenya and Ministry of Foreign Affairs of Finland, 2022b).

Recommendation 7: Continue to enroll as many individuals as possible in certified trainings in Mediation, Counselling and Alcohol and substance abuse, with a continued great focus on grassroot and front-line professionals. Ensuring core competencies simultaneously across sectors helps create a more predictable and reliable response and establishes a level of minimum accountability that allows for a realistic pathway to sustain improved quality in services for GBV survivors.

Recommendation 8: Identify or develop new certified training programmes that cover new topics on leadership, management, data analysis, planning, monitoring and evaluation that are useful skills for policy coordination.

Vision: Critical mass of knowledge and core competencies.

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Annex 2 – P3 referral form

The Kenya Police Service Medical Examination form, generally referred to as the P3 form in practices, serves as the main tool for intersectoral management of cases of GBV (although the tool is for any kind of assault and not just GBV). It is either issued at the police station or downloaded from the internet. Part I is to be filled by a police officer, and Part II by a health practitioner or the police surgeon as evidence that an assault has occurred. The P3 form is the link between the health and the judiciary system. The medical officer who fills out the P3 form or their representative will be expected to appear in court as an expert witness and produce the document in court as an exhibit. (UN Women and partners, 2019)

THE KENYA POLICE **P3**
MEDICAL EXAMINATION REPORT

PART 1-*(To be completed by the Police Officer Requesting Examination)*

From……..Ref……
……..Date……..
To the……Hospital/Dispensary
I have to request the favour of your examination of:-
Name……..Age……(If known)
Address…….....Date and Time of the alleged offence.....
……...
Sent to you/Hospital on the……20…..under escort of……
……and of your furnishing me with a report of the nature and extent of bodily injury sustained by him/her.
Date and time report to police……
Brief details of the alleged offence……
……
……..
Name of Officer Commanding Station Signature of the Officer Commanding Station

PART 11-MEDICAL DETAILS - *(To be completed by Medical Officer or Practitioner carrying out examination)*
*(Please type **four** copies from the original manuscript)*
SECTION ''A''-THIS SECTION MUST BE COMPLETED IN ALL EXAMINATIONS

Medical Officer's Ref.NO……
1. State of clothing including presence of tears, stains (wet or dry) blood, etc.
……
……
……
2. General medical history (including details relevant to offence)……
……
……
3. Genaral physical examination (including general appearance, use of drugs or Alcohol and demeanour)
……

This P3 Form is free of charge

SECTION ''B''- TO BE COMPLETED IN ALL CASES OF ASSAULT, INCLUDING SEXUAL ASSAULTS, AFTER THE COMPLETION OF SECTION ''A''

1. Details of site, situation, shape and depth of injures sustained:-
   a) Head and neck……
   ……
   ……
   b) Thorax and Abdomen……..
   ……
   ……
   c) Upper limbs……
   ……..
   ……
   d) Lower limbs ……
   ……
   ……
2. Approximate age of injuries (hours, days, weeks)……
   ……
3. Probable type of weapon(s) causing injury……
   ……
4. Treatment, if any, received prior to examination……
   ……
5. What were the immediate clinical results of the injury sustained and the assessed degree, i.e.''harm'', or' grievous harm''.*

DEFINITIONS:-
''Harm'' Means any bodily hurt, disease or disorder whether permanent or temporary.

''Maim' means the destruction or permanent disabling of any external or organ, member or sense

''Grievous Harm'' Means any harm which amounts to maim, or endangers life, or seriously or permanently injures health, or which is likely so to injure health, or which extends to permanent disfigurement, or to any permanent, or serious injury to external or organ.

……
Name & Signature of Medical Officer/Practitioner

Date……

This P3 Form is free of charge

SECTION "C"-TO BE COMPLETED IN ALLEGED SEXUAL OFFENCES AFTER THE COMPLETION OF SECTIONS "A" AND "B"

1. Nature of offence……Estimated age of person examined……

2. FEMALE COMPLAINANT

a) Describe in detail the physical state of and any injuries to genitalia with special reference to labia majora, labia minora, vagina, cervix and conclusion……
……
……
……

b) Note presence of discharge, blood or venereal infection, from genitalia or on body externally……
……
……
……

3. MALE COMPLAINANT

b) Describe in detail the physical state of and any injuries to genitalia……
……
……
……
……

c) Describe in detail injuries to anus……..
……
……

d) Note presence of discharge around anus, or/ on thighs, etc.; whether recent or of long standing……
……
……

This P3 Form is free of charge

SECTION "D"

4. **MALE ACCUSED OF ANY SEXUAL OFFENCE**

a) Describe in detail the physical state of and any injuries to genitalia especially penis……
……
……
……
……

b) Describe in detail any injuries around anus and whether recent or of long standing……
……
……
……
……

5. Details of specimens or smears collected in examinations 2 ,3 or 4 of section "C" including pubic hairs and vaginal hairs……
……
……

6. Any additional remarks by the doctor……
……
……
……

……
Name & Signature of Medical Officer/Practitioner

Date……

This P3 Form is free of charge

Annex 3 - PCR form

The Post Rape Care (PRC) form is a medical form filled by a medical practitioner, e.g., a medical officer, a clinical officer or a nursing officer, when attending to a survivor. The form documents relevant information on the survivor's history, their physical examination, and findings from the investigation is documented. The PRC form strengthens the development of an evidence chain of custody by having a duplicate that can be used for legal purposes and showing what specimens were collected, where they were sent, and who signed them. When the PRC form is completed and signed, the original form is to be given to the police for custody. This is the form that is produced in court as evidence. (UN Women and partners, 2019)

MINISTRY OF HEALTH

POST RAPE CARE FORM (PRC)
MOH 363

PART A & B

County: _____

Sub-County: _____

Facility: _____

Start Date: _____ **End Date:**_____

POST RAPE CARE FORM (PRC) **PART A**

MOH 363 PRC FORM IS NOT FOR SALE

Ministry of Health/National Rape Management Guidelines: Examination documentation form for survivors of rape/sexual violence (to be used as clinical notes to guide filling in of the P3 form)

PRC

MOH 363

OB /GYN History	Parity	Contraception type	LMP	Known Pregnancy? ☐ Yes ☐ No	Date of last consensual sexual intercourse	
General Conditions	BP	Pulse Rate	RR	Temp	Demeanor /Level of anxiety (calm, not calm)	

Date of Exam	Day	Month	Year	County Code	Sub-county Code Facility Name	OPD/IP No. MFL Code

Name(s) (Three Names) | Date of birth: Day | Month | Year | ☐ Male ☐ Female

Contacts (Residence and Phone number) _____

Disabilities. (Specify) _____ | Marital Status (specify) _____

Orphaned vulnerable child (OVC) ☐ Yes ☐ No | Citizenship _____

Date and time of Examination						Date and Time of Incident						No. of perpetrators
Day	Month	Year	Hr	Min	☐ AM ☐ PM	Day	Month	Year	Hr	Min	☐ AM ☐ PM	

Alleged perpetrators ☐ Male ☐ Female Estimated Age _____

☐ Unknown ☐ Known (specify the relationship) _____

Where incident occurred

Administrative location: County _____ Sub-county _____ Landmark _____

Chief complaints: Indicate what is observed _____

Indicate what is reported _____

Circumstances surrounding the incident (survivor account) remember to record penetration (how, where, what was used? Indication of struggle?)

_____

_____

Type of Sexual Violence	Use of condom?	Incident already reported to police?							
☐ Oral ☐ Vaginal ☐ Anal ☐ Other (specify) _____	☐ Yes ☐ No ☐ Unknown	☐ No ☐ Yes (indicate name of police station)							
		Date and time of report:	Day	Month	Year	Hr	Min	☐ AM ☐ PM	
		Attended a health facility before this one? ☐ No ☐ Yes (Indicate name of facility) _____				Were you treated? ☐ Yes ☐ No		Were you given referral notes? ☐ Yes ☐ No	
		Date: Day	Month	Year	Hr	Min	☐ AM ☐ PM		

Significant medical and/or surgical history

Comments: Indicate additional information provided by the client or observed by clinician

PHYSICAL EXAMINATION [indicates sites and nature of injuries bruises and marks outside the genitalia]

Please use the body map below to indicate injuries, inflammations, marks on various body parts of the survivor

BODY MAP

Comments

Anterior View

Posterior view

Female Genitalia

Male Genitalia

FORENSIC

Did the survivor change clothes?	State of clothes (stains, torn, color, where were the worn clothes taken)?
☐ Yes ☐ No	

How were the clothes transported? ☐ a) Plastic Bag ☐ b) Non Plastic Bag

☐ c) Other (Give details) _____

Were the clothes handed to the police? ☐ Yes ☐ No | Did the survivor go to the toilet? ☐ Long call? ☐ Short call?

Did the survivor have a bath or clean themselves? ☐ No ☐ Yes (Give details) _____

Did the survivor leave any marks on the perpetrator? ☐ No ☐ Yes (Give details) _____

GENITAL EXAMINATION OF THE SURVIVOR indicate discharges, inflammation, bleeding

Describe in detail the physical states

Physical injuries (mark in the body map) _____

Outer genitalia _____

Vagina _____

Hymen _____

Anus _____

Other significant orifices _____

Comments

Immediate Management	PEP 1st dose	ECP given	Stitching /surgical toilet done	STI treatment given
	☐ No ☐ Yes (No of tablets)	☐ No ☐ Yes	☐ No ☐ Yes(Comment)	☐ No ☐ Yes(Comment)

Any other treatment / Medication given /management?

Referrals to:

☐ Police Station ☐ HIV Test ☐ Laboratory ☐ Legal ☐ Trauma Counseling

☐ Safe Shelter ☐ OPD/CCC/HEV Clinic ☐ Other (specify)

LABORATORY SAMPLES	Sample Type	Test	Please tick as is applicable: National government Lab	Health Facility Lab	Comments
	Outer Genital swab	Wet/Pap Microscopy			
	Anal swab	DNA			
	Skin swab Oral swab Specify	Culture and sensitivity			
	High vaginal swab	Wet Prep Microscopy			
	Urine	Pregnancy Test			
		Microscopy			
		Drugs and alcohol			
		Other			
	Blood	Haemoglobin			
		HIV Test			
		SHPT/GHT			
		VDRL			
		DNA			
	Pubic Hair	DNA			
	Nail clippings	DNA			
	Foreign bodies	DNA			
	Other (specify)				

CHAIN OF CUSTODY

These (All / Some of the samples packed and issued (please specify)

By	Name of Examining Officer (Doctor/Nurse/Clinical officer)	Signature	Day	Month	Year
To	Police Officer's Name	Signature	Day	Month	Year

PSYCHOLOGICAL ASSESSMENT Complete psychological assessment section in Part B

POST RAPE CARE FORM (PRC)

PRC FORM IS **NOT** FOR SALE

PART B

PSYCHOLOGICAL ASSESSMENT

MOH 363

MOH 363

Part B is intended to assess the mental status of a client in order to be able to offer holistic care. This should inform the management and subsequent follow up of the client and hence should be filled in at presentation.

Psychological assessment should be done by trained health care providers including Medical Officers, Nurses, Clinical Officers, Psychiatrists, Psychological Counselors and Medical Social Workers duly recognized by the Ministry of Health.

The Medical Officers and other persons designated by law as expert witnesses in court (Nurses and Clinical Officers) should be the ones to sign off both the Part A and B of the PRC form.

General appearance and behavior

Note appearance (appear older or younger than stated age), gait, dressing, grooming (neat or unkempt) and posture.

Rapport

Easy to establish, initially difficult but easier over time, difficult to establish.

Mood

How he/she feels most days (happy, sad, hopeless, euphoric, elevated, depressed, irritable, anxious, angry, easily upset).

Affect

Physical manifestation of the mood e.g. labile (emotions that are freely expressed and tend to alter quickly and spontaneously like sobbing and laughing at the same time), blunt/ flat, appropriate/ inappropriate to context.

Speech

Rate, volume, speed, pressured (tends to speak rapidly and frenziedly), quality (clear or mumbling), impoverished (monosyllables, hesitant).

Perception

Disturbances e.g. Hallucination, feeling of unreality (corroborative history may be needed to ascertain details)

Thought content

Suicidal and Homicidal Ideation (Ideas but no plan or intent; clear/unclear plan but no intent; ideas coupled with clear plan and intent to carry it out); any preoccupying thoughts.

Thought process

Goal-directed/ logical ideas, loosened associations/ flight of ideas/ illogical, relevant, circumstantial (drifting but often coming back to the point), ability to abstract, perseveration (constant repetition, lacking ability to switch ideas).

(For children use wishes and dreams, and art/ play therapy to assess the thought process and content.

-Through drawing and play (e.g. use of toys). Allow the child to comment on the drawing and report verbatim.

-Assess the unconscious world of the child by asking about feelings e.g. ask the child to report the feeling that he/she commonly experiences and ask what makes him/her feel that way

Cognitive function-

a. Memory: Recent memory, long-term and short term memory (past several days, months, years).

b. Orientation: to time, place, person i.e. ability to recognize time, where they are, people around e.t.c.

c. Concentration: ability to pay attention e.g. counting or spelling backwards, small tasks

d. Intelligence: Use of vocabulary (compare level of education with clear presentation; above average, average, below average).

e. Judgment: Ability to understand relations between facts and to draw conclusions; responses in social situations.

Insight level: Realizing that there are physical or mental problems; denial of illness, ascribing blame to outside factors; recognizing need for treatment (Indicate whether insight level is; present, fair, not present)

Recommendation following assessment	Referral point/s

Referral uptake since last visit e.g. other medical services, children's department, police, legal aid, shelter e.t.c.

By	Name of Examining Officer (Doctor/Nurse/Clinical officer)	Signature	Day	Month	Year
To	Police Officer's Name	Signature	Day	Month	Year