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Evaluation of the UNTF-Funded Training and Technical Assistance Program in Kenya and DRC

Evaluation Report
Central and East Africa

October 2011 – February 2015

Prepared for

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PHR
Physicians for Human Rights

UNITED NATIONS TRUST FUND TO END VIOLENCE AGAINST WOMEN

RTI INTERNATIONAL

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List of Acronyms and Abbreviations

PHR
Physicians for Human Rights

UNTF
The UN Trust Fund to End Violence against Women

UNiTE
UNiTE to End Violence against Women campaign by the United Nations Secretary-General

RTI International
Research Triangle Institute

DRC
Democratic Republic of Congo

SGBV
Sexual and gender-based violence

PRC
Post Rape Care Form

BT
Basic forensic trainings

ToT
Training of trainers

GVRC
Gender-based violence recovery center

COVAW
Coalition on Violence against Women

PII
Personally Identifiable Information

TOR
Terms of Reference

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Executive Summary

Context and Project Being Evaluated

Millions of women in Central and East Africa will be raped or experience other sexual violence. Professionals in systems that provide services to survivors often lack the training or resources to provide full care for survivors of sexual and gender-based violence. Physicians for Human Rights (PHR) began working with health care providers, police officers, lawyers, and judges in Kenya and the Democratic Republic of the Congo (DRC) in 2011 to provide professionals with the resources, knowledge, and skills needed to support victims of sexual violence. As the demand to address sexual violence and the gaps in medical and legal systems grow in Kenya and DRC, this evaluation will shed light on the effectiveness of strategies employed by PHR as it continues its work in this region.

Purpose and Objectives of Evaluation

The overall objectives of the evaluation are to (1) Evaluate the entire project in terms of effectiveness, relevance, efficiency, sustainability and impact, with a strong focus on assessing the results at the outcome and project goal levels; (2) Generate key lessons and identify promising practices for learning; and (3) Inform the greater scientific and practitioner communities about the impact of the project.

Intended Audience

PHR and the United Nations Trust Fund to End Violence against Women (UNTF).

Methodology

This project used a mixed-methods evaluation strategy. Medical record reviews were conducted in Nakuru, Kenya (n=400); Kisumu, Kenya (n=400); and Minova, DRC (n=336). A core set of variables concerning medical record quality and medical evidence collected was examined relative to the date of PHR program exposure in each location (June 2013 in Nakuru, January 2013 in Kisumu, and May 2013 in Minova). Data were collapsed by month and Prais-Winsten regression estimates were used to account for potential autocorrelation in the errors and to assess changes in selected measures relative to the potential program exposure period. The qualitative component included 26 semistructured interviews (Kenya 16, DRC 10) with individuals who could provide information pertaining to the core evaluation criteria provided by the UNTF. A grounded theory approach was adopted to code and analyze data for themes. Other program data were used to answer questions pertaining to the core evaluation criteria.

Findings and Conclusions

There is evidence to support that the program was able to achieve change within its goal of survivors benefiting from a survivor-centered approach when receiving services from the health, legal, and law enforcement sectors. Particular outputs, such as increased knowledge and skills in documentation and professionals participating in cross-sectoral networks, appeared to play a major role in the project's ability to achieve change within its goal.

Recommendations

The program should focus on sustainability and continue to find ways to work with local institutions to integrate training-of-trainers into local training programs. Continuing to close gaps between best practice recommendations in the collection of forensic evidence with the resource restrictions and limitations posed by local jurisdictions will remain an ongoing challenge that should continue to be addressed.

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1. PROJECT CONTEXT AND BACKGROUND

1.1 Context of the Project

Throughout their lives, millions of women in Central and East Africa will be raped or experience other sexual violence. Data from national surveys estimate that 1.69 million to 1.8 million women have a history of rape in the Democratic Republic of the Congo (DRC),[1] and 21%, or one in five, of women have a history of sexual violence in Kenya.[2] Violent conflict and mass rape have left vast amounts of women and girls suffering and in need of medical and legal support, but professionals in those systems do not have the training or resources to provide full care for survivors of sexual and gender-based violence (SGBV). Medical education in Kenya and DRC provides limited training in forensic evidence and documentation, and health care professionals lack the equipment to collect full evidence. Police officers, lawyers, and judges are limited by similar resource constraints and need training to properly investigate and assess cases of sexual violence. Physicians for Human Rights (PHR) began working with health care providers, police officers, lawyers, and judges in Kenya and DRC in 2011 to provide professionals with the resources, knowledge, and skills needed to support victims of sexual violence. As the demand to address sexual violence, and the gaps in medical and legal systems, grows in Kenya and DRC, this evaluation will shed light on the effectiveness of strategies employed by PHR as it continues its work in this region.

1.2 Description of the Project

1.2.1 Project duration, start date, and end date

The project, "Formation of a Medico-Legal Network to Address Sexual Violence in Armed Conflict in Central and Eastern Africa," was implemented by PHR starting on January 9, 2011, and ending on February 28, 2015.

1.2.2 Description of the specific forms of violence addressed by the project

The project aims to build capacity and collaborative engagement of local health, legal, and law enforcement professionals in their efforts to improve medical evidence for successful prosecutions and convictions of perpetrators of sexual violence in the DRC and Kenya so that perpetrators are held accountable; future crimes can be deterred; and women and girls may obtain justice, including reparations. Additionally, the program aligns with and will contribute to the Secretary-General's UNiTE to End Violence Campaign 2008–2015 supporting women.

1.2.3 Main objectives of the project

PHR and its partners conduct local and regional training workshops and create a network of local forensic SGBV experts. The program team performed field assessments, drafted training curricula, moderated discussion forums, and employed role-playing exercises as teaching tools while giving technical support for training workshops and intranetwork communication. The project's key objectives are (1) training health and legal professionals in forensic skills for prosecutions; (2) forging new alliances between formerly unconnected health and legal actors in support of women and children survivors; (3) helping to achieve a gradual increase of medical evidence and testimonies for prosecutions of perpetrators at local

[1] Peterman, A., Palermo, T., & Bredenkamp, C. (2011). Estimates and determinants of sexual violence against women in the Democratic Republic of Congo. *American Journal of Public Health, 101,* 1060–1067.
[2] Kenya National Bureau of Statistics (KNBS) and ICF Macro. (2010). *Kenya demographic and health survey 2008–09*. Calverton, MD: Authors.

and national levels; and (4) adopting a woman- and girl-centered response across the continuum of the justice system.

1.2.4 Importance, scope, and scale of the project, including geographic coverage

The program currently works in the DRC and Kenya. To date, the program has conducted trainings in the DRC (Goma, Minova, Uvira, Bukavu, and Bunyakiri) and in Kenya (Nairobi, Kisumu, Naivasha, Nakuru, and Eldoret). In light of security concerns due to current active conflict in the Central African Republic and civil war in South Sudan, PHR received approval from the United Nations Trust Fund to End Violence against Women (UNTF) to redirect program activities away from these countries.

1.2.5 Strategy and theory of change (or results chain) of the project; brief description of project goal, outcomes, outputs, and key project activities

This project is based on the premise that visible, successful prosecutions and convictions as well as provision of judicial remedies such as court-imposed compensation for victims will deter future crimes. This premise has been endorsed by the UN Special Rapporteur on Violence against Women; by the Special Representative of the Secretary-General; numerous government leaders, including the U.S. Secretary of State Hillary Rodham Clinton; and by local colleagues in countries where sexual violence is widespread and systematic. Medical colleagues from Panzi Hospital in Bukavu, DRC, have repeatedly told PHR that unless there is visible and successful prosecution of rape in South Kivu, the crimes will continue to escalate, with the high number of survivors continuing to flood the hospital.

PHR engages with local health and legal professionals by conducting national and regional training workshops and creating networks of forensic SGBV experts. The program team also performed field assessments, drafted training curricula, moderated discussion forums, and planned meetings while providing technical support for training workshops and intranetwork communication. To demonstrate the most effective ways for health and legal professionals to conduct relationships with survivors and others, this innovative training strategy involves role-playing exercises as a teaching tool through which all of the stages, from first responder to the judicial process, are dramatized with participants.

In the short term, the program is a response to sexual violence against women and children that has already occurred, with medicolegal alliances created to support prosecutions of those responsible and justice and recovery for survivors.

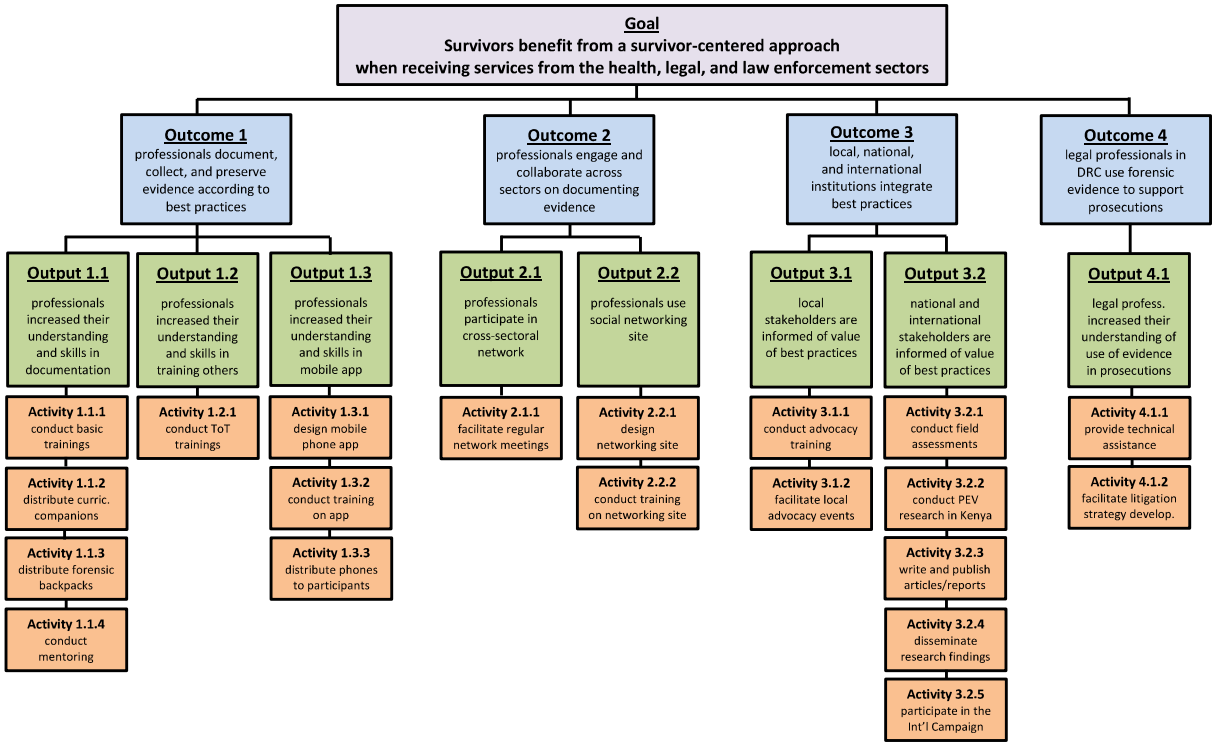
Program goal

Enhance local and international medical and legal skills and capacities, including medical, investigative, and judicial processes, to ensure greater success for survivors of sexual violence seeking to pursue their cases in national and international courts and to secure accountability for perpetrators of these crimes.

Program outcomes and outputs

Figure 1 details the relationships between the program's outcomes and outputs.

Figure 1. Program Outcomes and Outputs



Key program activities

- Train and mentor health, law enforcement, and legal (including judicial) professionals to effectively collect, document, analyze, and preserve forensic medical and other evidence to support and strengthen local prosecutions through basic forensic trainings (BT) for cross-sectoral cohorts in Kenya and DRC. Further develop PHR's advanced trainings in Kenya and DRC on forensic photography, pediatric evaluations, documentation on the Post Rape Care (PRC) form in Kenya and the forensic medical certificate in DRC, and competency-based trainings on medical evaluations using standardized patients.
- Develop curriculum for and convene Post Rape Care s (ToT) to build new cohort of certified local trainers in each focus country.
- Develop innovative mobile technologies to facilitate the collection, documentation, and preservation of forensic medical evidence for sexual violence prosecution.
- Embed long-term consultants in each country to provide ongoing training and mentorship as needed.
- Convene follow-up judicial colloquium to train and support judges.

1.2.6 Key assumptions of the project

The program's primary assumption is that combatting impunity surrounding sexual violence will act as a preventative measure against SGBV, as perpetrators are less likely to commit crimes if there is a danger of being prosecuted. This assumption itself rests on the assumption that stronger forensic medical evidence will bolster local prosecution of sexual violence, which will in turn reduce the impunity for

these crimes. As such, the program also assumes that well-trained doctors and law enforcement will gather better evidence that will be used to prosecute perpetrators of sexual violence and in turn reduce the incidence of sexual violence.

1.2.7 Description of targeted primary and secondary beneficiaries as well as key implementing partners and stakeholders

Primary beneficiaries:

The primary beneficiaries of the project are women and girls in conflict and postconflict zones of the DRC and Kenya. Because the project aims to improve capacities to prosecute, punish, and enforce reparation for rape, the cohort of beneficiaries theoretically extends to potential victims as well as actual survivors in that this initiative is viewed as a prevention measure through the deterrence potential of increased effective prosecutions. This number is in the millions.

Secondary beneficiaries:

Secondary beneficiaries include all the professionals in each country who have participated in the training sessions. This group represents 851 doctors, nurses, clinical officers, social workers, police officers, civilian and military prosecutors, lawyers, magistrates, judges, media representatives, and nongovernmental organization advocates who have gained specific technical skills and deeper understanding regarding the development and documentation of forensic evidence of sexual violence. A smaller group of 40 professionals who are mostly in the health sector have benefited from our Advanced Training modules. These individuals have developed the ability and opportunities to disseminate training to others in their communities and beyond.

Implementing partners and stakeholders:

Stakeholders and partners include PHR, Panzi Hospital in Bukavu, the United Nations Development Programme, Kenyatta National Hospital's Gender-based Violence Recovery Centre, the Coalition on Violence Against Women (COVAW), Bukavu General Hospital, HEAL Africa Hospital, Minova Hospital, Jaramogi Oginga Odinga Teaching and Referral Hospital, Avocats Sans Frontieres, American Bar Association—ROLI, Moi Teaching and Referral Hospital, Uvira hospital, military justice, Avocats Sans Frontières, and MONUSCO in DRC; and ICJ-Kenya, IMLU, Kenya Human Rights Commission, Liverpool VCT, and Nairobi Women's Hospital in Kenya..

1.2.8 Budget and expenditure of the project

The program was funded by United Nations Trust Fund to End Violence against Women up to the maximum amount of US$625,000. Over the 3.5 years of implementation PHR expended US$622,744.13.

1.3 Purpose of Evaluation

1.3.1 Why the evaluation needs to be done

This is a mandatory final project evaluation required by the United Nations Trust Fund to End Violence against Women (UNTF). The evaluation activities that have been conducted to date focus on the direct outcomes of the program of personnel in the medical, law enforcement, and legal sectors. The evaluation is intended to show the impact of the PHR program at the level of survivors of sexual assault. As such, a medical record review was conducted to capture survivor-level outcomes concerning the collection of forensic evidence from the survivors in the medical sector. To triangulate findings concerning the linkages between sectors that have been built in support of survivors of sexual assault, semistructured qualitative interviews were conducted with personnel in the medical, law enforcement, and legal sectors.

1.3.2 How the evaluation results will be used, by whom, and when

The evaluation results will be delivered 2 months after the end of the program. The program's ongoing evaluation efforts have been used previously to inform program development and to refine program quality and strategy. The program will continue beyond the end of the project period, and thus the impact evaluation will be used in a similar manner. The impact evaluation will also be published in a peer-reviewed journal to further inform other stakeholders of the results of the evaluation.

1.3.3 What decisions will be taken after the evaluation is completed

Decisions will be made regarding how the program further focuses its efforts on the collection and processing of forensic evidence in sexual assault cases. This may include refining approaches taken to train physicians, nurses, law enforcement officers, lawyers, and/or judges.

1.3.4 Context of evaluation

A team of researchers from RTI International, along with a consultant from Kenyatta University in Nairobi, Kenya, conducted this evaluation in cooperation with program team members from PHR. All data collection activities took place within organizations trained by PHR in Kenya and DRC. The in-country consultant sent the data collected for analysis by the RTI evaluation team. RTI is an independent, nonprofit research institute based in Research Triangle Park, NC, USA, with multidisciplinary staff experienced in conducting evaluations in regions across the globe. Detailed methodology of the evaluation is provided in following sections.

1.4 Evaluation Objectives and Scope

1.4.1 Scope of evaluation:

Time frame:

This evaluation covers project activity that began in October 2011 and ended in February 2015. Medical records were retrospectively evaluated to cover preproject periods (before October 2011) and project periods (October 2011–February 2015).

Geographical coverage:

This evaluation covers PHR project activities that took place in the Eastern DRC and in the Rift Valley Region of Kenya. A multistage cluster sampling strategy or a purposive sampling strategy was used to select medical facilities for inclusion in the medical record review.

Target groups to be covered:

This evaluation triangulates survivor-level impact through two major units of analysis: (1) the medical records of survivors of sexual assault and (2) the provider/trainee perceptions of changes in the collection and processing of sexual assault evidence across sectors.

1.4.2 Objectives of evaluation: What are the main objectives that this evaluation must achieve?

The overall objectives of the evaluation are to

- evaluate the entire project in terms of effectiveness, relevance, efficiency, sustainability, and impact, with a strong focus on assessing the results at the outcome and project goal levels;
- generate key lessons and identify promising practices for learning; and

- inform the greater scientific and practitioner communities about the impact of the project.

1.4.3 Key challenges and limits of the evaluation

The evaluation has a few limitations. First, results from the qualitative interviews with law enforcement, legal, and medical sector staff can be generalized only to those who participated in an interview. However, we strategically focused on staff who were in areas in which PHR conducted extensive training, and our findings reflect the experiences and perceptions of those in these locations.

1.5 Evaluation Team

The Evaluation Team consisted of 1 national Kenyan consultant and 3 international USA-based consultants.

Evaluator A: Dr. Mike Anastario Research Sociologist at RTI International was responsible for undertaking the evaluation from start to finish and for managing the evaluation team under the supervision of evaluation task manager from the grantee organization, for the data collection and analysis, as well as report drafting and finalization in English.

Evaluator B: Dr. Kelle Barrick, Research Criminologist at RTI International's Center for Justice, Safety, and Resilience assisted Dr. Anastario to undertaking the evaluation from start to finish and for managing the evaluation team under the supervision of evaluation task manager from the grantee organization, for the data collection and analysis, as well as report drafting and finalization in English.

Evaluator C: Rose Werth, Public Health Analyst at RTI International assisted Dr. Anastario to undertaking the evaluation from start to finish and for managing the evaluation team under the supervision of evaluation task manager from the grantee organization, for the data collection and analysis, as well as report drafting and finalization in English.

Consultant: Dr. Francis Malenya will work with the Evaluators to assist with on-the-ground data collection, logistics, and translation of data from local languages (where applicable) to English.

The tables below show a brief description of each member's roles and responsibilities in the evaluation as well as a timeline for the evaluation.

Table 1. Management arrangement of the evaluation

Name of Group	Role and responsibilities	Actual name of staff responsible
Evaluation Team	External evaluators/consultants to conduct an external evaluation based on the contractual agreement and the Terms of Reference, and under the day-to-day supervision of the Evaluation Task Manager.	External evaluators
Evaluation Task Manager	Someone from the grantee organization, such as project manager and/or M&E officer to manage the entire evaluation process under the overall guidance of the senior management, to: • lead the development and finalization of the evaluation TOR in consultation with key stakeholders and the senior management;	Tom McHale, Program Officer, Program on Sexual Violence in Conflict Zones

	• manage the recruitment of the external evaluators; • lead the collection of the key documents and data to be share with the evaluators at the beginning of the inception stage; • liaise and coordinate with the evaluation team, the reference group, the commissioning organization and the advisory group throughout the process to ensure effective communication and collaboration; • provide administrative and substantive technical support to the evaluation team and work closely with the evaluation team throughout the evaluation; • lead the dissemination of the report and follow-up activities after finalization of the report	
Commissioning Organization	Senior management of the organization who commissions the evaluation (grantee) – responsible for: 1) allocating adequate human and financial resources for the evaluation; 2) guiding the evaluation manager; 3) preparing responses to the recommendations generated by the evaluation.	Karen Naimer, Director, Program on Sexual Violence in Conflict Zones
Reference Group	Include primary and secondary beneficiaries, partners and stakeholders of the project who provide necessary information to the evaluation team and to reviews the draft report for quality assurance	Primary beneficiaries include survivors who sexual violence who receive services from first responders being trained. Secondary beneficiaries include law enforcement, judicial officials, and medical professionals who directly participated in the training program.
Advisory Group	Must include a focal point from the UN Women Regional Office and the UN Trust Fund Portfolio Manager to review and comment on the draft TOR and the draft report for quality assurance and provide technical support if needed.	Veronica Zebadua Yanez, Program Specialist, Farida Deif, Deputy Manager

Table 2. Work plan and timeline of evaluation

Stage of Evaluation	**Key Task**	**Responsible**	**Number of working days required**	**Time frame** (dd/mm/yyyy - dd/mm/yyyy)

Preparation stage	Prepare and finalize the TOR with key stakeholders	Commissioning organization and evaluation task manager	10	26/11/2014-19/12/2014
	Compiling key documents and existing data		1	17/12/2014
	Recruitment of external evaluator(s)		1	26/11/2014
Inception stage	Briefings of evaluators to orient the evaluators	evaluation task manager	2	01/12/2014-15/01/2015
	Desk review of key documents	Evaluation Team	3	01/12/2015-15/01/2015
	Finalizing the evaluation design and methods	Evaluation Team	3	01/12/2015-15/01/2015
	Preparing an **inception report**	Evaluation Team	0	N/A
	Review Inception Report and provide feedback	Evaluation Task Manager, Reference Group and Advisory Group	0	N/A
	Submitting final version of **inception report**	Evaluation Team	0	N/A
Data collection and analysis stage	Desk research	Evaluation Team	10	18/02/2015-28/02/2015
	In-country technical mission for data collection (visits to the field, interviews, questionnaires, etc.)	Evaluation Team	60	01/03/2015-29/04/2015
Synthesis and reporting stage	Analysis and interpretation of findings	Evaluation Team	20	20/04/2015-10/05/2015
	Preparing a **draft report**	Evaluation Team	10	10/05/2015-20/05/2015
	Review of the draft report with key stakeholders for quality assurance	Evaluation Task Manager, Reference Group, Commissioning Organization Senior Management, and Advisory Group	3	20/05/2015-23/05/2015
	Consolidate comments from all the groups and submit the consolidated comments to evaluation team	Evaluation Task Manger	2	23/05/15-25/05/15
	Incorporating comments and revising the evaluation report	Evaluation Team	3	25/05/15-28/05/15
	Submission of the **final report**	Evaluation Team	3	25/05/15-28/28/15
	Final review and approval of report	Evaluation Task Manager, Reference Group,	3	28/05/15-31/05/15

		Commissioning Organization Senior Management, and Advisory Group		
Dissemination and follow-up	Publishing and distributing the final report	commissioning organization led by evaluation manager	30	01/06/15-30/06/15
	Prepare management responses to the key recommendations of the report	Senior Management of commissioning organization	14	01/07/15-15/07/15
	Organize learning events (to discuss key findings and recommendations, use the finding for planning of following year, etc.)	commissioning organization	30	16/07/15-15/08/15

1.6 Evaluation Questions

The key questions that need to be answered by this impact evaluation, as requested by the UNTF, include the mandatory evaluation questions illustrated in Table 3. The mandatory evaluation questions correspond to five overall evaluation criteria – relevance, effectiveness, efficiency, sustainability, and impact. This impact evaluation was designed to best speak to the mandatory evaluation questions given the time and resources available.

Table 3. Evaluation criteria and questions

Evaluation Criteria	Mandatory Evaluation Questions
Effectiveness	1) To what extent were the intended project goal, outcomes and outputs achieved and how? 2) To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? How many beneficiaries have been reached? 3) To what extent has this project generated positive changes in the lives of targeted (and untargeted) women and girls in relation to the specific forms of violence addressed by this project? Why? What are the key changes in the lives of those women and/or girls? Please describe those changes. 4) What internal and external factors contributed to the achievement and/or failure of the intended project goal, outcomes and outputs? How?
Relevance	1) To what extent was the project strategy and activities implemented relevant in responding to the needs of women and girls? 2) To what extent do achieved results (project goal, outcomes, and outputs) continue to be relevant to the needs of women and girls?
Efficiency	1) How efficiently and timely has this project been implemented and managed in accordance with the Project Document?

Sustainability	1) How are the achieved results, especially the positive changes generated by the project in the lives of women and girls at the project goal level, going to be sustained after this project ends?
Impact	1) What are the unintended consequences (positive and negative) resulted from the project?
Knowledge Generation	1) What are the key lessons learned that can be shared with other practitioners on Ending Violence against Women and Girls? 2) Are there any promising practices? If yes, what are they and how can these promising practices be replicated in other projects and/or in other countries that have similar interventions?

1.7 Evaluation Methodology

Table 4. Evaluation Methodology

Subsections	Inputs by the evaluator(s)
Description of evaluation design	The evaluation uses a mixed-methods design that includes semistructured interviews with training participants and longitudinal medical record review. The participant interviews capture perceptions of the training and how it has impacted the work processes for legal, medical, and law enforcement professionals. The medical record review captures changes in medical documentation and forensic evidence collected before and after the trainings.
Data sources	Interviews Medical records
Description of data collection methods and analysis (including level of precision required for quantitative methods, value scales or coding used for qualitative analysis, level of participation of stakeholders through evaluation process, etc.)	MEDICAL RECORD REVIEW *Quantitative data collection* The quantitative design was a pretest and posttest without comparison group. A power analysis was conducted to determine the sample size for reviewing medical records pre- and post-training. Pre-PHR program exposures include medical records 2009–2011; post-PHR program exposures include medical records 2012–2015. Group sample sizes of 189 and 189 produce a two-sided 95% confidence interval for the difference in population proportions with a width that is equal to 0.200 when the estimated sample proportion 1 is 0.50 and the estimated sample proportion 2 is 0.60. The medical record review was set at n=400 at each site. The time series analysis pools observations by month; however, we wanted to maximize the stability of estimates that would be collapsed into each month. Three sites were selected for analysis based on the location of the PHR training programs. Record reviews were conducted at the following facilities: Rift Valley Provincial General Hospital in Nakuru, Kenya; Jaramogi Oginga Odinga Teaching and Referral Hospital in Kisumu, Kenya; and Hopital General de Reference in Minova, DRC. Medical records for all patients with a diagnosis of sexual violence who visited any of the three facilities from 2009 through 2015 were considered eligible for selection in the medical review (start and end dates for data collection varied by site, but

	included a total span of 67 months in which the survivor could present to the health care facility). Within each facility, sexual violence records were first sorted by year, and sampling intervals were determined within each year to facilitate the systematic random selection of cases from the facility. Thirty -six codes were assigned to each medical record (the medical record coding guide is provided in Annex 4 of this report). Measures were focused on medical record quality and medical evidence collected for a single patient. In total, 400 medical records were collected in Nakuru, 400 in Kisumu, and 336 in Minova (because of restrictions on data access). *Quantitative data analysis* Medical record data were analysed using STATA 13.[3] A core set of variables concerning medical record quality and medical evidence collected was examined relative to the date of PHR program exposure in each location (June 2013 in Nakuru, January 2013 in Kisumu, and May 2013 in Minova). Data were cleaned to eliminate cases from the analytic dataset that failed logic and consistency checks. The data were collapsed by month of presentation to a health care facility, and binary data were collapsed into each month (ranging 0 to 1) for a specific variable. We used the Prais-Winsten regression estimator to account for potential autocorrelation in the errors and to assess changes in selected measures relative to the potential program exposure period. Specific quantitative analyses were conducted for each evaluation criteria domain and will be described separately in the results section. SEMISTRUCTURED INTERVIEWS Interviewees were selected from a training participant list provided by PHR. *Qualitative data collection* Data for this mixed-methods study are drawn from field research conducted in Kenya and the eastern DRC in the first quarter of 2015. Semistructured interviews were conducted with PHR trainees in Kenya and DRC. These trainees included members of the law enforcement, health care, and legal sectors within each country. We conducted 26 semistructured interviews (Kenya 16, DRC 10) with individuals who could provide information pertaining to the core evaluation criteria provided by the UNTF (effectiveness, relevance, sustainability, impact, and knowledge generation). Interviews were audio-recorded and transcribed in the language of the interview (Swahili, English). All manuscripts were translated into English (if needed) and subjected to analysis.

[3] StataCorp. (2013). *Stata statistical software: Release 13*. College Station, TX: StataCorp LP.

	Qualitative analysis For the qualitative research, we adopted a grounded theory approach in which we systematically coded and analyzed data for emergent themes. Such an approach emphasizes the interplay between data collection and analysis, as well as the emergence of theory from data.[4] Because specific questions were included in the semistructured interview instrument that corresponded to the mandatory evaluation questions specified by the UNTF, answers to these specific questions were flagged as occurring within an evaluation criteria domain. Transcripts were uploaded into Atlas.ti.15,[5] which was used to generate the open codes. Open codes were first developed within each country, and codes were not crossed between countries. All text within Kenya and DRC interviews was thus subject to separate rounds of open coding, with flags inserted during the open coding process to specify which evaluation criteria domain the text referred to. All open codes were sorted by the evaluation criteria domain flag before axial codes were developed. A total of 1,617 open codes were developed (995 in Kenya, 622 in DRC), followed by 45 axial codes (22 Kenya, 22 in DRC). We treated the evaluation criteria domains as the theoretical codes and thus present the qualitative results relative to these domains, converting each axial code into a paragraph under that heading. EXISTING PROGRAM DATA Other existing program data were used to inform specific questions related to the core evaluation criteria. To answer questions concerning reach of the program, we analyzed pre- and posttraining questionnaires administered by the program. Questions included background characteristics of the services the respondents provide, including the number of sexual violence cases the trainee has actively examined, interviewed, or represented in the 12 months preceding the training. To answer questions concerning efficiency, we analyzed quarterly billing and number of persons trained.
Description of sampling • Area and population to be represented • Rationale for selection • Mechanics of selection limitations to sample • Reference indicators and benchmarks/baseline, where relevant (previous indicators, national statistics, human rights	**Medical Record Review** Health care facilities in Nakuru, Kisumu, and Minova with medical personnel trained by PHR were included in the medical record review. Medical records were randomly selected for inclusion in the evaluation using a sampling interval. Medical records were first sorted by date and the number of records each year was counted. The sampling interval was based on the number of cases needed from each facility (n=400). Records were listed sequentially and every *nth* record was selected for inclusion.

[4] Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative research*. Thousand Oaks, CA: Sage.
[5] ATLAS.ti Qualitative Analytic Software. (2008). Berlin: Author.

treaties, gender statistics, etc.)	**Semistructured Interviews** Interviews were conducted with a purposive sample of PHR trainees. We aimed to sample personnel from medical, legal, and law enforcement sectors within Kenya and DRC who were trained by PHR and who could report on changes observed. Twenty-six semistructured interviews were conducted: 16 in Kenya and 10 in the DRC.
Description of ethical considerations in the evaluation • Actions taken to ensure the safety of respondents and research team • Referral to local services or sources of support • Confidentiality and anonymity protocols • Protocols for research on children, if required	RTI's institutional review board (IRB) reviewed the protocol and determined that data collected are intended to evaluate the PHR program and will be provided to PHR and the UN Trust Fund for use in further developing programs and policies that take into account the results of the evaluation. If the parameters of these activities change such that the data could be used for scientific purposes to contribute to generalizable knowledge (e.g., in the form of a scientific publication in a peer-reviewed journal), RTI IRB review and approval of an exemption request may be required. Interview participants are not asked to provide any personally identifiable information (PII). If PII is provided, it is redacted from the interview transcript. PII is not collected in the medical record review.
Limitations of the evaluation methodology used	First, quantitative medical record data are representative of sexual assault cases that were documented in the medical records at three facilities in locations where PHR was active (Kisumu, Nakuru, and Minova). It is possible that other effects may be observed in sites not selected. Second, data were collected and coded in as systematic a manner as possible; however, record-keeping systems and diagnoses are likely to vary across sites and time, producing potentially unobserved changes in outcomes. Qualitative analyses are specific to the sample of individuals selected; however, the purposive selection criteria ensured that we could obtain a wider reach of those whose practices would be affected by PHR program exposure.

1.8 Findings and Analyses by Evaluation Question

Table 5.1 Effectiveness findings

Evaluation Criteria	Effectiveness
Evaluation Questions	To what extent were the intended project goal, outcomes, and outputs achieved, and how?
Response to the evaluation question with analysis of key findings by the evaluation team	The project's goal was that survivors benefit from a survivor-centered approach when receiving services from the health, legal, and law enforcement sectors. This goal was associated with four outcomes and eight outputs. There is ample evidence throughout this report that professionals made changes to document and collect evidence in accordance with the PHR training (Outcome 1). This outcome was primarily achieved through direct training activities provided by the program (Output 1.1), and not yet in a training-of-trainers (ToT) capacity (Output 1.2). The program just began fielding the mobile app module in 2015 (Output 1.3), and thus this outcome appears to be most effectively achieved through Output 1.1. There is evidence that professionals made changes to document and collect evidence in accordance with the PHR training (Outcome 2). This outcome was primarily achieved through participation in network activities (Output 2.1) rather than through the use of a social networking site (Output 2.2). There is evidence that the program made efforts to inform local, national, and international institutions to integrate best practices. There is evidence that the program engaged local (Output 3.1), national, and international stakeholders (Output 3.2). The extensive change in documentation practices evidence throughout this report, coupled with evidence that suggestions for integrating best practices are being distributed at the local, national, and international levels, suggests that integration of best practices is occurring. There is evidence of change in the understanding (Output 4.1) and use (Outcome 4) of forensic evidence to support prosecutions among legal professionals in the DRC, with a perception that an increasing number of convictions are occurring for sexual assault cases in program-affected areas in the DRC. Improvements in medical record quality, medical evidence collection measures, attention provided to survivors across sectors concerning evidence collection and transfer, and attention to the needs of survivors helped the program achieve change within its goal of survivors' benefiting from a survivor-center approach when receiving services from the health, legal, and law enforcement sectors.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	Below, evidence is broadly considered for each log model component illustrated in Figure 1 of this report. Results pertaining to Outcome 1, Output 1.1, Output 1.2, and Output 1.3 are primarily found in Tables 5.2, 5.3, Table A, Table C, and Table 5.4, and Table 7 below. There was ample qualitative evidence of professionals increasing their understanding and skills in documentation across sectors (Output 1.1), and the medical record review illustrates changes in medical record quality and medical evidence collection associated with postprogrammatic exposure

	periods in the health care sector. With regard to professionals increasing their understanding and skills in training others (Output 1.2), there remains a need for training of trainers (ToT) efforts to be implemented. While the mobile app was not part of this evaluation (Output 1.3), preliminary usability data was collected during the first field test of the app in January 2015, and is available upon the UNTF's request. Overall, professionals reported (qualitatively) and were measured in the health care (quantitatively) as making changes to documentation quality and evidence collection measures (Outcome 1). Results pertaining to Outcome 2, Output 2.1, and Output 2.2 are primarily found in Table 5.3, Table 5.4, Table 8, and Table 10. There was ample evidence that professionals associated with the PHR training participated in a cross-sectoral network (Output 2.1), but it was not evidence that this was done through the use of a social networking site (Output 2.2). Overall, professionals reported (qualitatively) engaging and collaborating across sectors on documenting evidence. Regarding informing local stakeholders of best practices (Output 3.1), the program has at minimum held 5 local advocacy events and met with 13 local stakeholders. Further, individuals who could be considered local stakeholders were invited to trainings. Regarding Output 3.2, the program met with at minimum 21 stakeholders regarding the value of integrating best practices in support of women and girl survivors of sexual violence, and the program has held an active record of media involvement, with 64 mentions in the media and 46 blog posts. Magistrates, law enforcement officers, and leadership in health care were included in trainings that demonstrated best practices. With support from Kenyan colleagues, the sexual violence program sponsored an open-access publication in PLoS One: *Time Series Analysis of Sexual Assault Case Characteristics and the 2007–2008 Period of Post-Election Violence in Kenya (2014). PLoS ONE 9(8): e106443. Doi : 10.1371 / journal.pone. 0106443*. PHR's cross-sectoral approach was also referenced in an annex in the UK's International Protocol on Prosecuting and Investigation Sexual Violence and the Medical Certificate PHR helped to create in DRC was included as an annex to the protocol as a model medical-legal form. PHR was also invited to launch a film about the program at the opening plenary at the UK's Global Summit to End Sexual Violence in Conflict in London in June 2014. At the Summit, Secretary of State John Kerry referenced PHR's work in DRC and Kenya in his closing keynote address. PHR also published a summary report on a Roundtable discussion held in conjunction with Georgetown University and the Columbia University School of International Public Affairs on reparations for victims of sexual violence in the DRC, issued in 2014. Additionally, PHR published a summary report of the Roundtable discussion held in Nairobi, Kenya in February 2015 bringing together stakeholders from Kenya and DRC to share best practices and outline the way forward for regional collaboration. Finally, stakeholders are invited to trainings. As stakeholders were involved in trainings, results

	supporting Outcome 3, Output 3.1, and Output 3.2 are also found in Tables 5.2, 5.3, Table A, Table C, and Table 5.4, and Table 7 below. Concerning Outcome 3, there is extensive documentation of change in medical record quality and evidence collection, coupled with changes documented across legal and law enforcement sectors in trainee practice. These changes are effected in part by discretionary effort and in part by systemic change, some of which was facilitated by the networks supported by PHR. Results supporting Outcome 4 and Output 4.1 are primarily provided in Tables 5.3, Table 5.4, Table 6, and Table 9 below. Evidence supporting output 4.1 comes from legal professionals in DRC who reported conducting more detailed investigations with greater reliance on medical and forensic evidence following training. Further, legal personnel participated in committees concerned with revision to the medical certificate. Legal respondents in DRC perceived an increasing number of convictions. As it concerns outcome 4, practitioners reported knowing of many cases where their evidence or testimony had helped convict perpetrators. One lawyer reported 15 convictions of 20 cases he could recall. Many respondents attributed increasing convictions to the higher quality of evidence. Tables regarding the project goal that survivors benefit from a survivor-centered approach when receiving services are primarily supported by findings reported in Table 5.2, Table 5.3, and Table 6 below. Medical record quality and medical evidence collection measures showed improvements relative to PHR program exposure periods. Improvements in the provision of survivor-centered care was reported across sectors, particularly pertaining to evidence collection, transfer, and the needs of survivors.
Conclusions	There is evidence to support that the program was able to achieve change within its goal of survivors' benefiting from a survivor-centered approach when receiving services from the health, legal, and law enforcement sectors. The evidence used to examine this impact was based on medical record review findings and qualitative interviews that also supported change in each of the outcome domains. Particular outputs, such as increased knowledge and skills in documentation and professionals participating in cross-sectoral networks, appeared to play a major role in the project's ability to achieve change within its goal.
Others	N/A

Table 5.2 Effectiveness findings

Evaluation Criteria	Effectiveness
Evaluation Questions	To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? How many beneficiaries have been reached?
Response to the evaluation question with analysis of key findings by the evaluation team	The program trained 851 health care, legal, and law enforcement representatives. The estimated number of sexual assault survivors reached by the PHR training was 17,448. In Kenya, trainees described adopting a more survivor-centered approach by providing increased confidentiality, enhanced referrals, and attention to psychological needs. In DRC, trainees described adopting a more survivor-centered approach by improving communication techniques, improving confidentiality, and minimizing distress.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	PRE AND POST TRAINING QUESTIONNAIRE FINDINGS We used pre and post training questionnaires administered to PHR trainees to estimate the overall number of sexual violence survivors that may have been affected by a change in the trainees practice. To estimate this effect, we analysed the distribution of the approximate number of sexual violence cases that participants reported actively examining/ interviewing/ representing in the 12 months preceding the training. Within the nine trainings that did not have repeat trainees, the median annual number of survivors examined/interviewed/represented was 12, and the mean was 38.7 (SD=94.6). Using the median, we multiplied by the number of people trained by the program each year, and we allowed for earlier trainees to be duplicated every 12 months. To extrapolate the more conservative estimate of the potential number of survivors reached by the PHR program, the 851 personnel trained would theoretically have implications for the 17,448 survivors of sexual violence who received services from PHR trainees. SEMISTRUCTURED INTERVIEW FINDINGS-KENYA *Interactions with Survivors (E-SURV)* The training was described as impacting the way that respondents interacted with and handled survivors. Respondents reported empathizing with the experience of survivors, describing the ways they tried to ease survivors' experience in the medical and legal systems. Police officers and medical providers described attempts to ensure the confidentiality of survivors, providing private rooms for exams and questioning: "Before there was no privacy, and when after the training we give the feedback to our supervisors they were able to provide us with a room whereby we examine these patients as well as do the counseling." They also prepared survivors for referral to other sectors, explaining next steps and attempting to provide greater support to survivors through the legal process. One police officer explained: "I normally guide them or through even when the matter is coming for hearing in court. I normally guide them through. I

	even help them to compose themselves once they are before the magistrate." Health care providers also described trying to limit patients' length of stay in the hospital and began attending to survivors' psychological trauma with greater care. One doctor provided an example: "So in terms of the examination and everything else, physically there was really no evidence of injury. But most of the trauma was psychological. So having been trained I was really able to pick out this and link her with our patient support center for more psychological support." SEMISTRUCTURED INTERVIEW FINDINGS-DRC *Interactions with Survivors (E-SURV)* Respondents from all sectors reporting changing the way that they approached and interacted with sexual violence victims. They spoke of improving communication and trying to minimize the distress of survivors during medical and legal processes. Two health care providers specifically mentioned using PHR techniques and materials to improve the way they greet and talk to survivors. "In terms of medical care, there are changes in terms of how you welcome the victims, the manner in which you talk to him/her and the manner of writing that report…but the manner of welcoming, talking to the victims and the examination technique, there are better techniques that we have acquired from PHR." Practitioners also attended to the concerns of victims, describing how they tried to respond to survivors' need for privacy, psychological care, and urgency.
Conclusions	At the outcome level, the project reached 851 personnel in the health care, legal, and law enforcement sectors across Kenya and the DRC. Participants across sectors learned how to collect, manage, and transfer evidence in support of the approximately 17,448 survivors they provided services to. Participants described changes in how they provided survivor-centered care, including attention to confidentiality and psychological wellbeing.
Others	

Table 5.3 Effectiveness findings

Evaluation Criteria	Effectiveness
Evaluation Questions	To what extent has this project generated positive changes in the lives of targeted (and untargeted) women and girls in relation to the specific forms of violence addressed by this project? Why? What are the key changes in the lives of those women and/or girls? Please describe those changes.
Response to the evaluation question with analysis of key findings by the evaluation team	Adequate medical documentation of sexual assault is part of the investigative process. The observation of improvements in medical documentation of sexual assault reflects services the survivor already received and evidence that is available for a prosecution. Overall, appreciable improvements were observed in documentation of the age of the perpetrator and the collection of an oral swab. The largest effect sizes for improvements in record quality were observed in Kisumu, whereas the least amount of changes were observed in Minova. Some effect sizes for Minova were negative. Qualitative interview data in Kenya suggest that evidence collection and management across sectors improved, as did interpretation of evidence and the provision of care to patients. Interview data in Kenya also suggest improvements to filling out sexual assault documentation, which cross-validates medical record review improvements, particularly in Kisumu. In DRC, general improvements in documentation and clarity concerning the forensic examination process led to outcomes in trainee practice.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	MEDICAL RECORD REVIEW FINDINGS In the medical record review results, there were improvements observed in the quality of medical records and the type of evidence collected within the medical record. Notable improvements were observed in the documentation of the age of the perpetrator (0.83 before PHR exposure, 0.95 after PHR exposure), documentation of the narrative description of events (0.95 before exposure, 0.98 after exposure), and collection of an oral swab (0.01 before exposure, 0.04 after exposure)(Table A). Small but notable changes occurred in the collection of pubic hair samples (0.0 before exposure, 0.01 after exposure) and the collection of other foreign bodies (0.00 before exposure, 0.01 after exposure) (Table A). The largest overall changes observed in the medical records are exhibited in Figure A. Prais-Winsten estimates for record quality measures (Table B) and evidence collected (Table C) were estimated by health care facility location. Overall, cases in the postexposure period showed an appreciably greater percentage-point increase in documentation of the age of the perpetrator (beta=.12, SE=0.06, $p<0.05$) (Table A), and taking an oral swab (beta=.04, SE=.01, $p<0.01$) (Table B). A reduction was observed in taking urine samples (beta=-0.009, SE=0.04, $p<0.05$) (Table B). In Nakuru, there was a reduction in the documentation of the time of assault (beta=-.17, SE=.05, $p<0.01$) (Table A), and an increase in taking pubic hair samples (beta=.03, SE=.01, $p<0.05$) (Table B).

In Kisumu, there was an appreciable percentage point increase in documentation of the time of assault (beta=0.40, SE=0.14, p<0.01), documentation of the age of the perpetrator (beta=0.59, SE=0.09, p<0.001), documentation of the chief complaint (beta=0.25, SE=0.10, p<0.05), and whether the survivor bathed (beta=0.03, SE=0.02, p<0.05) (Table B). Increases in the collection of oral swabs (beta=0.09, SE=0.03, p<0.05) and high vaginal swabs (beta=0.09, SE=0.06, p=0.139) were also observed (Table B).

In Minova, there were no appreciable changes in record quality measures (Table A). A non-statistically significant increase in the collection of anal swabs was observed (beta=0.017, SE=0.012, p=0.154), and a reduction in outer genital swabs (beta=-0.39, SE=0.18, p<0.05) and high vaginal swabs (beta=-0.11, SE=0.05, p<0.05) was observed (Table B).

SEMISTRUCTURED INTERVIEW FINDINGS-KENYA

Practices before Training (E-BASE)

Practitioners recognized the lack of knowledge and gaps in practices that existed before the training with PHR. Reflecting on their prior practices, doctors and police officers spoke of missing or mishandling evidence:

> "Most of the time I would lose a lot of evidence because collecting the evidence itself. I learned that you, for example, need to lay down a piece of paper so when the patient is taking off their clothes and so on, whatever remains and is falling off you collect it."

Without training, practitioners described gaps in knowledge and resources to conduct adequate investigations, medical examinations, and complete evidence collection. Health care providers reported lacking key equipment for child sexual assault cases, such as pediatric speculums. Health care providers also reported leaving documentation forms incomplete after examining a patient, one nurse saying "there were some few things we used to ignore in those forms when filling the documents." Police and health care providers also described magistrates being unable to understand or interpret medical forms.

Changes in Practice (E-PRAC)

After the training respondents changed key practices related to provision of care, evidence collection and documentation, and interpretation of evidence. Health care providers altered and improved many aspects of patient care and treatment. After training several providers who once referred all sexual violence patients to other facilities or providers began directly providing treatment to survivors themselves. Providers also offered more comprehensive care to patients, emphasizing counseling and psychosocial support in addition to sexual health and injury treatment. Changes in the practice of collecting medical forensic evidence began for some participants by simply using materials from the forensic backpacks distributed in PHR trainings. Doctors and nurses reported that the pediatric speculum and flashlights provided by PHR improved their ability to conduct patient

	examinations. The training also affected practices related to conducting the patient exam, taking patient history, and improving medical documentation. Providers reported collecting evidence from the exam and history in finer detail, collecting clothing and forensic particles for analysis and meticulously documenting body marks and injuries. Police officers also took a more active role in collecting evidence of sexual assaults, ensuring chain of custody documentation and improving the preservation of evidence. In both medicine and law enforcement sectors, respondents discussed using khaki envelopes or brown paper to wrap and package evidence. A laboratory analyst who regularly works with forensic evidence collected in sexual assault cases mentioned seeing improvements in police materials and in samples for high vagina swab collection. The training also led to changes in forms and the use of existing forms. Health care providers reported filling the government PRC and P3 forms more completely after the training, in some cases adding more space for the doctor's opinion or a diagrams to document injuries. One provider explained: "The only basic form we are using is the Post Rape Care Form, which we are now filling it fully. Because we have the knowledge. Before we could fill leaving some spaces because you don't know what is required in places of it." Some facilities also developed new tools to document or enhance evidence collection, patient intake, or standard operating procedures. Within the legal sector, magistrates and prosecutors began utilizing medical knowledge learned in trainings. They reported relying on new types of forensic evidence, and identifying relevant facts in medical evidence. A magistrate gave one example: "Sometimes you may not see anything physically on say the private parts of the person who has been traumatized, but if she was to tell you that this person forced me onto my knees, and the PHR form shows you injuries of the knees, injuries of the palms, you are able to know, piece together what the victim is talking about." SEMI-STRUCTURED INTERVIEW FINDINGS- DRC *Practices before Training (E-BASE)* The practitioners and officials from DRC acknowledged some mistaken beliefs and problematic practices that existed prior to the training. Respondents reported limited evidence collection practices and lacking knowledge of forensic techniques. One magistrate described how this affected legal cases: "You know earlier on we were not clear about or we did not understand the doctors. We would write their account of happenings and we would write our own account of events but we wouldn't understand each other, and so this would lead to a person who has committed a crime to be acquitted." Health care providers, legal, and judicial officials also recognized the miscommunication and lack of networking that occurred prior to training. *Changes in Practice (E-PRAC)*

	Respondents reported many changes to their documentation, patient care, evidence collection, and case management practices. Practitioners described improving their documentation practices, in particular how they created or supplemented forms. Several respondents began to ask survivors to write down their stories, adding a space on their reports for victim narrative. One doctor noted that they added a section to record more detailed information about the perpetrator(s). Other respondents changed forms to reflect new evidence collection practices, such as adding a diagram to document body marks and injuries. One respondent reported using a new form introduced across their county. Health care providers also improved the way they conducted patient examinations. Many found patient examination much easier after the training and tried to ensure that the patient's privacy was protected. Doctors relied on many of the materials in the forensic backpacks that were distributed, particularly mentioning the flashlights and speculum among other materials. Some medical providers reported using the pack as a back-up to hospital supplies, others used up the supplies from the pack and purchased or fell back on hospital materials. Both medical providers and law enforcement reported improving their evidence collection practices. Several respondents highlighted their new skills in forensic photography. Police and legal officials also reported conducting detailed investigations and cases, relying on medical and forensic evidence more than before.
Conclusions	Overall, improvements in medical documentation and sample collection translate into improved investigative services that were provided to survivors of sexual assault. Improvements in the collection of oral swabs were observed across sites. It appears that pubic hair and other foreign body sample collections may not have been occurring before the PHR training and that they began on a small scale after the PHR training. The largest, most positive improvements were observed in medical record quality in Kisumu. These medical record changes reflect health care services that were offered to survivors of sexual assault. Qualitative data suggest that trainees changed their practices across sectors to improve the collection and management of forensic evidence of sexual assault. Overall improvements in documentation carry implications for survivors who wish to bring cases to prosecution.
Others	See Tables A-C and Figure A below

Table A Overall medical record quality and medical evidence collected across Nakuru, Kisumu, and Minova sites[a]

Mean monthly percentage of cases with medical evidence collected, pre and postprogram exposure periods		
	Before program exposure	After program exposure
	(n=129)	*(n=72)*
Record quality measures		
Time of assault was documented	0.77	0.80
Age of the perpetrator was documented	0.83	0.95
Location of assault was documented	0.99	0.99
Chief complaint was documented	0.92	0.98
Whether survivor changed clothes was documented	0.99	1.00
Clothes placed in non-plastic paper bag was documented	1.00	1.00
Whether survivor bathed was documented	0.99	1.00
Narrative description was documented	0.95	0.98
Documentation of PCP/ECP/surg. procedures/STI trtmt.	1.00	1.00
Anatomical diagrams present in medical record	1.00	1.00
Referrals documented	0.99	0.96
Medical evidence collected		
Anal swab taken	0.08	0.08
Skin swab taken	0.00	0.00
Oral swab taken	0.01	0.04*
Outer genital swab taken	0.79	0.66
High vaginal swab taken[b]	0.95	0.92
Urine sample taken	1.00	0.99
Blood sample taken	1.00	1.00
Pubic hair sample taken	0.00	0.01
Nail clippings taken	0.00	0.00
Other foreign bodies collected	0.00	0.01

[a]*Based on 1,136 cases over 67 months*

[b]*Female cases only, male cases excluded from monthly denominator*

**p<0.01, probability values derived from unadjusted, bivariate Prais-Winsten analyses*

Figure A Pre and post program exposure values for the largest overall changes observed in medical record variables, Nakuru, Kisumu, and Minova sites, n=201 months representing 1,136 cases

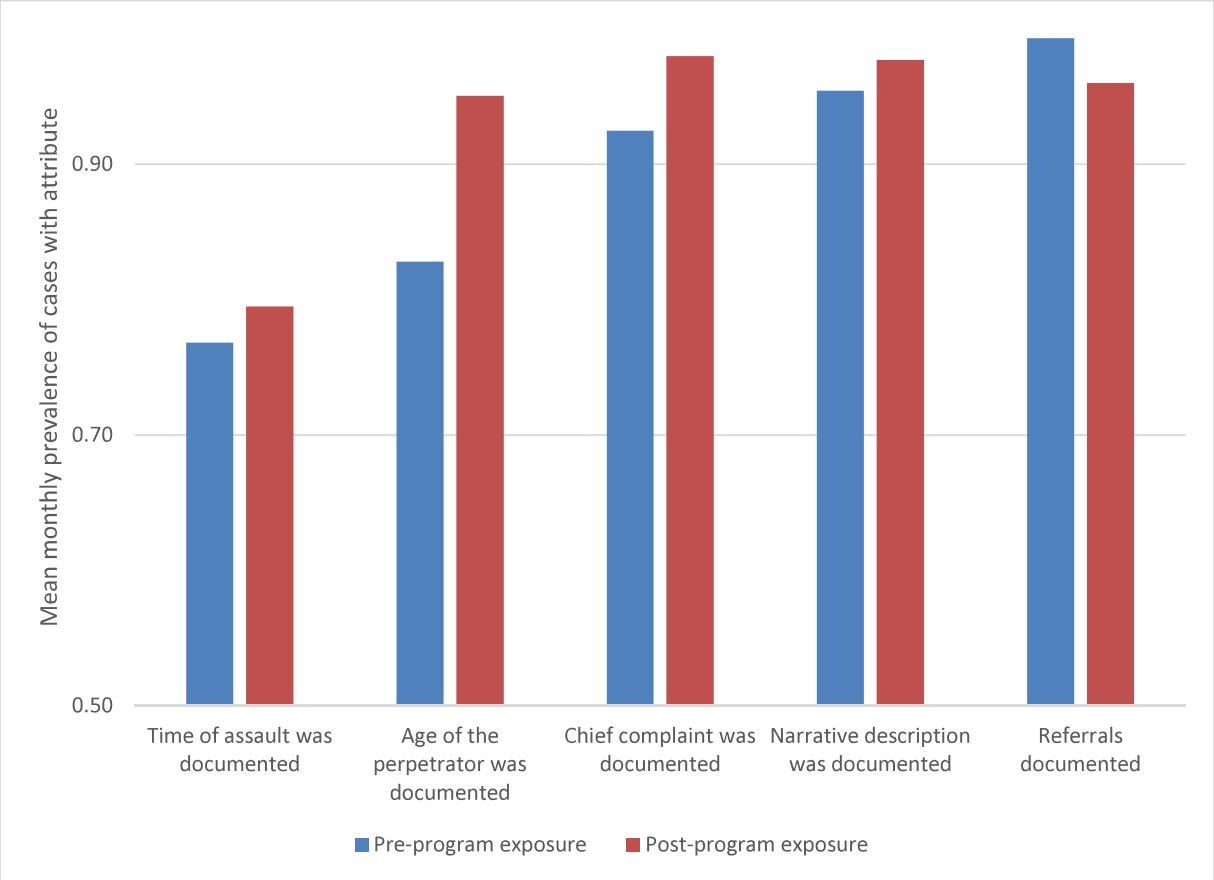


Table B Medical record quality measures relative to PHR program exposure periods[a]

Prais-Winsten estimates for postprogram exposure periods (comparison period is preprogram exposure)								
Record Quality Measures	**Overall**		**Nakuru**		**Kisumu**		**Minova**	
	(n=201)		(n=67)		(n=67)		(n=67)	
	Coef.	SE	Coef.	SE	Coef.	SE	Coef.	SE
Time of assault was documented	.03	.07	-.17**	.05	.40**	.14	-.102	.113
Age of the perpetrator was documented	.12*	.06	-.03	.02	.59***	.09	0	0
Location of assault was documented	-.003	.007	-.01	.02	.003	.002	0	0
Chief complaint was documented	.06	.04	-.01	.01	.25*	.10	0	0
Whether survivor changed clothes was documented	-.011	.03	-.06	.06	.03	.01	0	0
Clothes placed in non-plastic paper bag was documented	.004	.003	.004	.005	.008	.007	0	0
Whether survivor bathed was documented	.007	.005	0	0	.03*	.02	0	0
Narrative description was documented	.03	.02	0	0	.19	.13	0	0
Documentation of PCP/ECP/surg. procedures/STI trtmt.	0	0	0	0	.01	.01	0	0
Anatomical diagrams present in medical record	.001	.002	0	0	.007	.006	0	0
Referrals documented	-.03	.02	0	0	-.07	.06	0	0

[a]*Based on 1,136 cases over 67 months*

[*]*p<0.05, **p<0.01, ***p<0.001*

Table C **Medical evidence collection measures relative to PHR program exposure periods[a]**

Prais-Winsten estimates for postprogram exposure periods (comparison period is preprogram exposure)								
Medical evidence collected	**Overall**		**Nakuru**		**Kisumu**		**Minova**	
	(n=201)		(n=67)		(n=67)		(n=67)	
	Coef.	SE	Coef.	SE	Coef.	SE	Coef.	SE
Anal swab taken	-.007	.03	.005	.05	-.092	.08	.017	.012
Skin swab taken	.003	.003	0	0	-.002	.007	.009	.006
Oral swab taken	.04**	.01	.0004	.01	.09*	.03	.009	.006
Outer genital swab taken	-.13	.09	-.08	.16	.098	.064	-.39*	.18
High vaginal swab taken[b]	-.03	.03	-.03	.03	.09	.06	-.11*	.05
Urine sample taken	-.009*	.004	-.009	.007	-.012	.01	0	0
Blood sample taken	0	0	0	0	0	0	0	0
Pubic hair sample taken	.008	.006	.03*	.01	-.01	.009	0	0
Nail clippings taken	0	0	0	0	0	0	0	0
Other foreign bodies collected	.01	.01	.04	.03	0	0	0	0

[a]*Based on 1,136 cases over 67 months*
[b]*Female cases only, male cases excluded from monthly denominator*
[*]*p<0.05, **p<0.01*

Table 5.4 Effectiveness findings

Evaluation Criteria	Effectiveness
Evaluation Questions	What internal and external factors contributed to the achievement or failure of the intended project goal, outcomes, and outputs? How?
Response to the evaluation question with analysis of key findings by the evaluation team	The PHR program focused on building networks across sectors, which in turn facilitated the ability of trained personnel to better implement their learned material and provide investigative services to survivors of sexual assault. It appears that networks may have facilitated the feasibility of implementing training material with some degree of fidelity. These networks represent a site where participants can use local discretion to better facilitate change. In Kenya, networks formed through the PHR training affected the referral of survivors across sectors, as well as the flow of evidence and information between and across sectors. In DRC, respondents described providing increased attention to the referral process to improve cross-sector articulation. The use of networks thus had implications for providing survivor-centered approach (goal) and improving professional practice and implementation (outcomes). Improvements observed in medical documentation (Table A) could reflect how information is transmitted to clinicians, when it is transmitted, and how that information is used in the justice system. Equipment and general resource deficiencies in DRC appear to pose a continued challenge to training.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	SEMISTRUCTURED INTERVIEW FINDINGS- KENYA *Networking (E-NETW)* Networks formed through the PHR training changed the referral of survivors across sectors, as well as the flow of evidence and information between and across sectors. Health care providers reported implementing several strategies to improve referral of survivors between different service providers. Some facilities formed internal committees to coordinate referral or involved social workers: "Another thing is the involvement of a social worker. That one I make sure they've gone, because the social worker is the one who will make sure the survivor goes from all the departments 'til justice is found." Networks created within trainings also helped respondents improve referral of survivors between sectors. Practitioners called up contacts that they developed at trainings to refer survivors between the justice system and medical facilities. Police and doctors reported calling each other before referring survivors. Doctors also referred survivors to social workers, child protection officers, and safe houses. In addition to patient referral, networking activities established by the PHR program facilitated the movement of evidence through medical and justice systems. A police officer reported introducing the chain of custody form to other providers: "Using the chain of custody form I even introduced it in the hospital where you are, where some DNA samples are being collected. I know the doctors at the lab didn't know what to do with it so I could tell them this form, once you have collected the samples you have to indicate you are the ones who has collected it and once you've collected it and you've handed

	over to me, for the purpose of that continuity of that evidence activities presented before court." Respondents continued to share their knowledge across sectors after the training, spreading practices, or in the case of one prosecutor, calling to verify that doctors collected evidence fully. *Practices not Impacted (E-NG)* There were a few areas of practices for which respondents reported less change relative to the PHR program. In Kenya, the Ministry provides a Post Rape Care form for health care providers to document sexual violence. Some respondents described falling back to their regular interaction with this form after training without making additions or changes to their practices. One provider made no changes despite noting that that limited information gathered on the form made follow-up challenging. Two other respondents reported instances of limited change. The first, a doctor, had yet to receive a sexual violence case since training, and the second, a prosecutor, reported no changes in knowledge concerning medical or police documentation. SEMISTRUCTURED INTERVIEW FINDINGS- DRC *Networking (E-NETW)* Respondents from DRC focused less on the impact of networks on daily practices than did respondents from Kenya. However, they did discuss changes in how they referred survivors through medical and justice systems. Medical providers reported referring patients to the justice system more easily. One doctor, although not directly in other services, described how they prepared patients and reports to connect survivors to other providers and the justice system. Respondents also described changing how they filled reports so that they would be more intelligible to other sectors. "The kind of report we used to do was one that was not very clear, but now our reports are very detailed and adequate and can be understood easily. And this makes it possible to reduce the number of times the officers in the courts of justice call on us to go and explain our evidence." In one case, the doctors and judicial officials worked together to revise the medical certificate form used in sexual violence cases. Medical providers, law enforcement, and legal official also reported consulting one another and working together on sexual violence cases. *Practices not Impacted (E-NG)* Most practitioners and officials reported making significant changes to practices after the training. However, a few respondents noted some areas that had not changed or where they continued to struggle. Some doctors said that they had not changed their medical or care practices after the training, but noted that they had received feedback from PHR indicating that they were doing well. One provider expressed confidence in their treatment services: "It has been there since before PHR and it has just been good, and so on this there may not be a big difference. We had

	confidence in our work and so even when PHR came they told us, 'Yes, let us continue with this and that.' And so we did." A few doctors also reported having continued issues with their equipment. One provider noted that they had to discard their speculum due to overuse, and another mentioned that they still did not have the equipment needed to collect evidence from clothing.
Conclusions	Networks built across health care, law enforcement, and legal sectors facilitated an improvement in the management and collection of forensic evidence for sexual assault survivors. In Kenya, the strategic use of network building also facilitated trainees' implementing their training. In DRC, more emphasis was placed on referrals, and resource deficiencies continue to pose a challenge to training. Although many spurious factors beyond the scope of this evaluation may contribute to differential effects on the impacts, outcomes, and outputs, it appears that networks contributed to the project's outcomes and impact, and resource deficiencies in DRC continue to pose a challenge.
Others	N/A

Table 6. Relevance findings

Evaluation Criteria	Relevance
Evaluation Questions	1) To what extent were the project strategy and activities implemented relevant in responding to the needs of women and girls? 2) To what extent do achieved results (project goal, outcomes, and outputs) continue to be relevant to the needs of women and girls?
Response to the evaluation question with analysis of key findings by the evaluation team	Medical evidence of sexual assault is relevant to all survivors of sexual assault regardless of gender identity; however, this project did achieve results that were relevant to the needs of women and girls. The vast majority of medical records examined (90%) pertained to female cases, in which improvements were observed in record quality and medical evidence collected. Within female records only, large changes were observed for documentation of the age of the perpetrator, and an increase in the collection of oral swabs also occurred. In Kenya, qualitative evidence suggests that trainees had sizeable and relevant caseloads of patients who may have benefited from changes resulting from the PHR training. In addition to changing practices that affect services, it is possible that other effects on women and girls (e.g., the promotion of reporting, increased trust in the health care system) occurred. In DRC, PHR trainees reported high rates of contact with survivors of sexual assault. Among some participants, the request of funds from survivors terminated after the PHR training, and some participants observed that general community effects may have taken place (more cases coming forward) because of changes in the perception of the justice system.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	MEDICAL RECORD FINDINGS Across all sites, approximately 1,021 of 1,135 medical records (90%) were for female cases (80% of Kisumu records, 92% of Nakuru records, and 99.7% of Minova records were female cases). Table D documents the results of a time series analysis where only female cases are used to generate estimates for each of the 67 months in the analysis. Within this subset of female cases, a significant increase occurred in the percentage of cases where an oral swab was taken (0.01 before program exposure, 0.05 after program exposure, $p<0.01$). A large effect in oral swabs occurred for female cases in Kisumu, at 0.0 before program exposure and 0.10 after program exposure ($p=0.022$). While the overall sample showed a slight reduction in high vaginal swabs, the Kisumu cases also showed an increase in high vaginal swabs (0.82 before training, 0.91 after training, $p=0.139$). A statistically significant reduction in the collection of urine samples was also observed (1.0 before program exposure, 0.99 after program exposure, $p<0.05$). The largest effect size observed was for documentation of the age of the perpetrator (0.81 before program exposure, 0.91 after program exposure, $p=0.112$) (Table D). SEMISTRUCTURED INTERVIEW FINDINGS – KENYA *Reaching Relevant Providers (R-REACH)* Most respondents reported handling sexual violence cases on a regular basis. Some health care providers had only screened a few

	cases for sexual violence since the training, but many had larger caseloads ranging from dozens to hundreds of cases. One health care provider reported treating as many as 50 to 60 cases per month since the training. One police officer reported investigating 8 cases since the training, while another reported investigating around 60 cases per year. *Addressing Needs of Women and Girls (R-ADD)* Most respondents reported that the training was relevant to the needs of women and girls and survivors of sexual violence. The health care providers, police officers, and legal officials described relevance in terms of how the training affected their work with survivors of sexual violence. Health care providers explained how the training gave them new skills in patient care, evidence collection, and documentation, allowing them to provide more holistic care. A few health care providers spoke of the need for this training, reporting that they were never taught these skills during their education. Some providers mentioned other activities that came out of the training relevant to the needs of survivors, such as the formation of committees addressing SGBV or sexual violence awareness talks given in communities or hospital waiting rooms. Police officers also described changes in their practices as relevant, citing cases where they tried to connect survivors to treatment or advocate for their cases in court. One magistrate felt that the training taught him how to create a safe environment for survivors to testify. Respondents reported feeling like the changes in their work led to stronger cases and addressed survivors' need for justice. They also reported guiding colleagues on their sexual violence cases, trying to help them address the survivors' needs as well. *Outcomes for Women and Girls (R-OUT)* Respondents described a number of positive outcomes for women and girls that they felt had resulted from the training. Many of the health care providers and police officers interviewed described seeing an increase in reporting or survivors encouraging other women to report and receive treatment for sexual violence. One police officer reported: "They are able to share with others, and they are encouraging other survivors to come out. Those who have been maybe sexually violated, and they didn't know what to do they are now being encouraged by those ones we have handled in our facility." Some respondents attributed these changes to women being more informed, having more faith in medical and judicial systems, and experiencing less stigma when reporting. Some respondents reported improved legal outcomes, mentioning cases with improved prosecution and convictions. Health care providers also described improvements seen in patients who received counselling. Some reported that since implementing changes in care, more survivors were returning for follow-up: "So the outcomes for those who have been handled by well-trained colleagues, they fare better. Because you find even their follow-up is good because they feel cared for when they come to the hospital, and therefore they will still want to continue coming for subsequent follow-up."

	A few respondents described mixed outcomes. A couple of health care providers reported survivors mistrusting the hospital and not knowing what to do when they experience sexual violence. SEMISTRUCTURED INTERVIEW FINDINGS – DRC *Reaching Relevant Providers (R-REACH)* The respondents interviewed reported high contact with sexual violence cases. The minimum number of cases a provider reported screening since the training was 10, but others reported seeing 20 or more cases every week or every month. One doctor reported seeing too many cases to estimate. Police officers and lawyers also described dealing with sexual violence cases on a regular basis. *Addressing Needs of Women and Girls (R-ADD)* Practitioners and officials reported feeling that the training had addressed the needs of women and girls, as well as filling an urgent need in their country to address sexual violence. One magistrate said that sexual violence was commonplace in DRC and saw widespread sexual violence from both civilians and the military. Respondents also described a general lack of education on how to handle sexual violence cases and how this leads to poor or corrupt practices. Several doctors spoke of the gaps that existed between the legal and medical sectors before training, and one magistrate mentioned working with doctors collecting money from victims before the training. Respondents also discussed how the training addressed these issues and improved their ability to handle cases. Doctors reported improving their overall quality of care and collecting stronger evidence for cases. One provider explained the changes: "Many of them used not to get justice from the judgement often given due to lack of enough evidence. But as nurse I used not to collect, capture the evidence very well. Sometimes they would have torn clothes and I used not to take note of that…but now because I have trained I cannot give something weak. It's very concrete. I have to collect all evidence and that evidence can help more the victim to have justice than before." A magistrate described a case where they moved a victim from a corrupt hospital to a facility trained by PHR: "But you see this is Africa so the perpetrator gave some money to the doctor and the doctor wrote a report indicating that the child was okay and she never had any sexual intercourse with any man. So this case got to my office so I got hold of the girl and took her to Panzi hospital where PHR was operating from. So PHR-trained doctor's examination was truthful compared to the earlier one which was all lies." Respondents also felt that the training improved their capacity to help survivors achieve justice. Doctors reported improving their referrals to the justice system, and a couple respondents believed that sexual assault was declining because perpetrators were beginning to fear conviction: "And even now we have observed that people even fear going to commit rape because they know that if they do it, they will be jailed. Earlier, it was like even one commits rape, he will just

	know how to go about it. But now since they know that if I rape, I will be jailed for 20 to 30 years you see rape cases have started coming down gradually according to a recent report as compared to the occurrences of past years." *Outcomes for Women and Girls (R-OUT)* Although a few respondents were unsure of survivors' ultimate outcomes, most practitioners reported seeing many positive outcomes resulting from the training with PHR. Doctors, lawyers, and police officers described survivors healing because of improved care and practices. They saw patients improving through treatment and counseling, returning for follow-ups. Lawyers and police officers also felt that their interactions with survivors helped them improve and reach positive long-term outcomes. Several respondents also reported noticing survivors' opinions of medical and justice systems change after the training. Respondents attributed these changes to the help and care that survivors had received, along with an increasing number of convictions. They felt that survivors were becoming more hopeful and reporting more easily. One military police officer described a case where a survivor who had felt hopeless came to house for help after hearing a notice on the radio about available sexual assault services.
Conclusions	The project strategy and results were relevant and continued to be relevant to the needs of women and girls. Within the medical records of female survivors of sexual violence, the documentation of perpetrator age improved, along with an increase in the collection of an oral swab. In Kisumu, it appears that taking oral swabs began in the period associated with post-PHR program exposure. These changes reflect changes in medical services offered to female survivors of sexual violence. The sizeable caseloads in both countries, coupled with changes to practices, were perceived as affecting changes in the community, which might have produced increased reporting and justice system engagement among women and girls.
Other	See Table D below

Table D Medical record measures relative to PHR program exposure periods across Nakuru, Kisumu, and Minova sites, female cases only[a]

Mean monthly percentage of cases with medical evidence collected, pre and post-program exposure periods		
	Before program exposure	After program exposure
	(n=129)	*(n=72)*
Record quality measures		
Time of assault was documented	0.78	0.80
Age of the perpetrator was documented	0.81	0.91
Location of assault was documented	1.00	0.99
Chief complaint was documented	0.94	0.98
Whether survivor changed clothes was documented	0.99	0.98
Clothes placed in non-plastic paper bag was documented	1.00	1.00
Whether survivor bathed was documented	0.99	1.00
Narrative description was documented	0.95	0.98
Documentation of PCP/ECP/surg. procedures/STI trtmt.	1.00	1.00
Anatomical diagrams present in medical record	1.00	1.00
Referrals documented	0.99	0.97
Medical evidence collected		
Anal swab taken	0.03	0.06
Skin swab taken	0.00	0.00
Oral swab taken	0.01	0.05**
Outer genital swab taken	0.83	0.70
High vaginal swab taken	0.95	0.92
Urine sample taken	1.00	0.99*
Blood sample taken	1.00	1.00
Pubic hair sample taken	0.00	0.01
Nail clippings taken	0.00	0.00
Other foreign bodies collected	0.00	0.02

[a]*Based on 1,021 female cases over 67 months*

*$p<0.05$, **$p<0.01$

Table 7. Efficiency findings

Evaluation Criteria	Efficiency
Evaluation Questions	1) How efficiently and timely has this project been implemented and managed in accordance with the Project Document?
Response to the evaluation question with analysis of key findings by the evaluation team	The program was able to execute training with increased efficiency relative to its spending and its originally stated training targets. This efficiency estimate is specific to training (Outcome 1), and is meant to represent how the program utilized funds to achieve its reach. The positive correlation of billing to numbers trained suggests that the number of personnel trained indicator is an acceptable metric for the purposes of this efficiency analysis.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	In order to answer questions concerning program efficiency, we focused here on the number of individuals trained within the project period, which is an indicator pertaining to what is perhaps the most resource intensive component of the program. Thus the efficiency calculation is a crude estimate that does not reflect program spending on other activities, but that is intended to represent how the program implemented its core activities relative to its spending. The target number of trainees over a 3-year program period was 375 trainees. The actual number of trainees trained over the 3-year program period was 851. The overall amount billed by the program over 40 months was $622,744.13. Thus, the target ratio was 1660.7 per trainee. The actual ratio was 731.80 per trainee. The program was able to reach its intended number of beneficiaries at the end of 2nd year (Figure B). As it regards spending within annual project periods (annualized estimates used to capture lags in billing/training cycles, including cost extensions in the 3rd year), the billing/persons trained correlation was 0.95 (see Figure C).
Conclusions	The program was able to execute training, its core activity, with increased efficiency relative to its originally stated targets.
Other	See Table E, Figures B and C below

Table E. Program funding and persons trained

Project Timeline (months)	Cumulative		Within 6-month project periods	
	Project funding billed	Persons trained	Project funding billed	Persons trained
6	$78,578.91	96	$78,579	96
12	$132,899.21	186	$54,320	90
18	$213,406.31	269	$80,507	83
24	$346,019.13	417	$132,613	148
30	$430,620.13	613	$84,601	196
36	$443,151.13	766	$12,531	153
42	$622,744.13	851	$179,593	85

Figure B. Cumulative number of individuals trained by 6-month billing periods, relative to target number of persons trained (target illustrated in red)

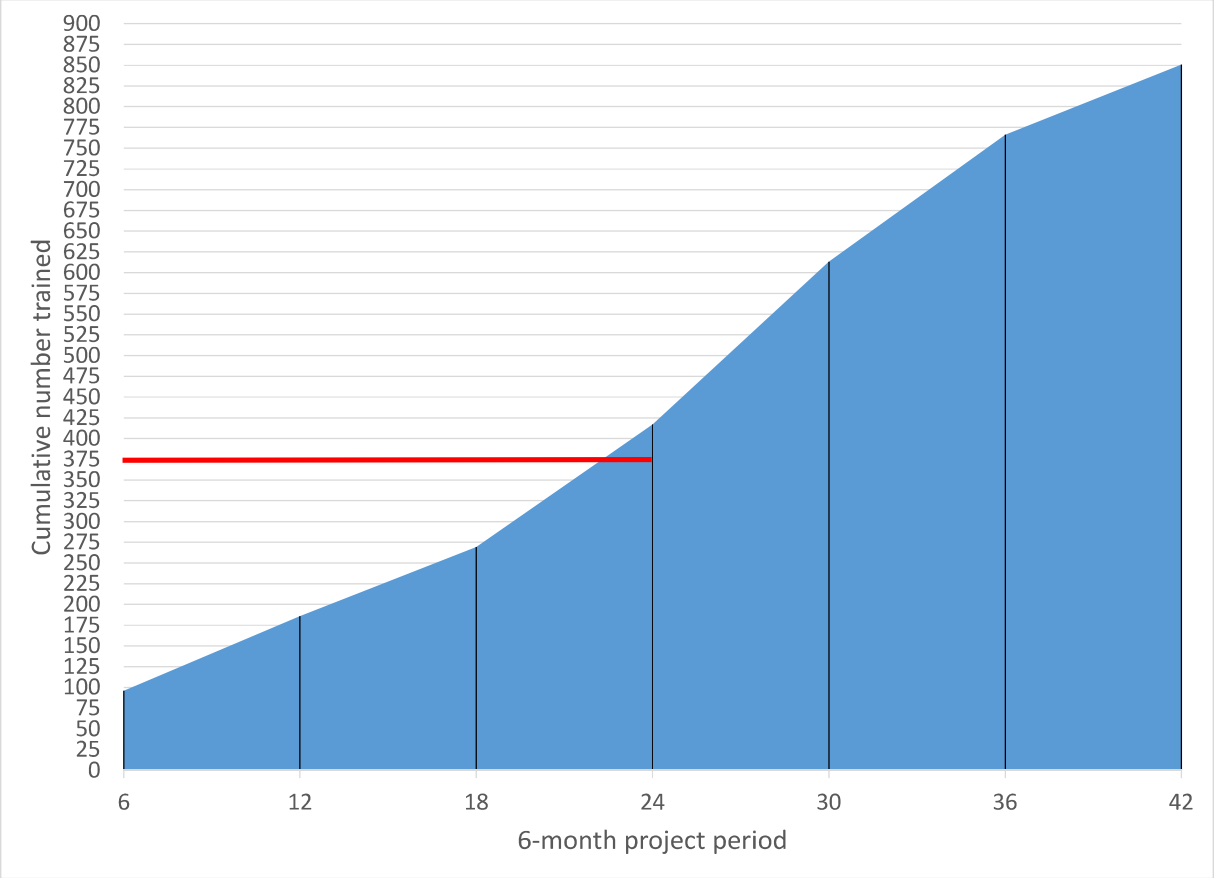


Figure C. Dollars billed and number of persons trained, annually

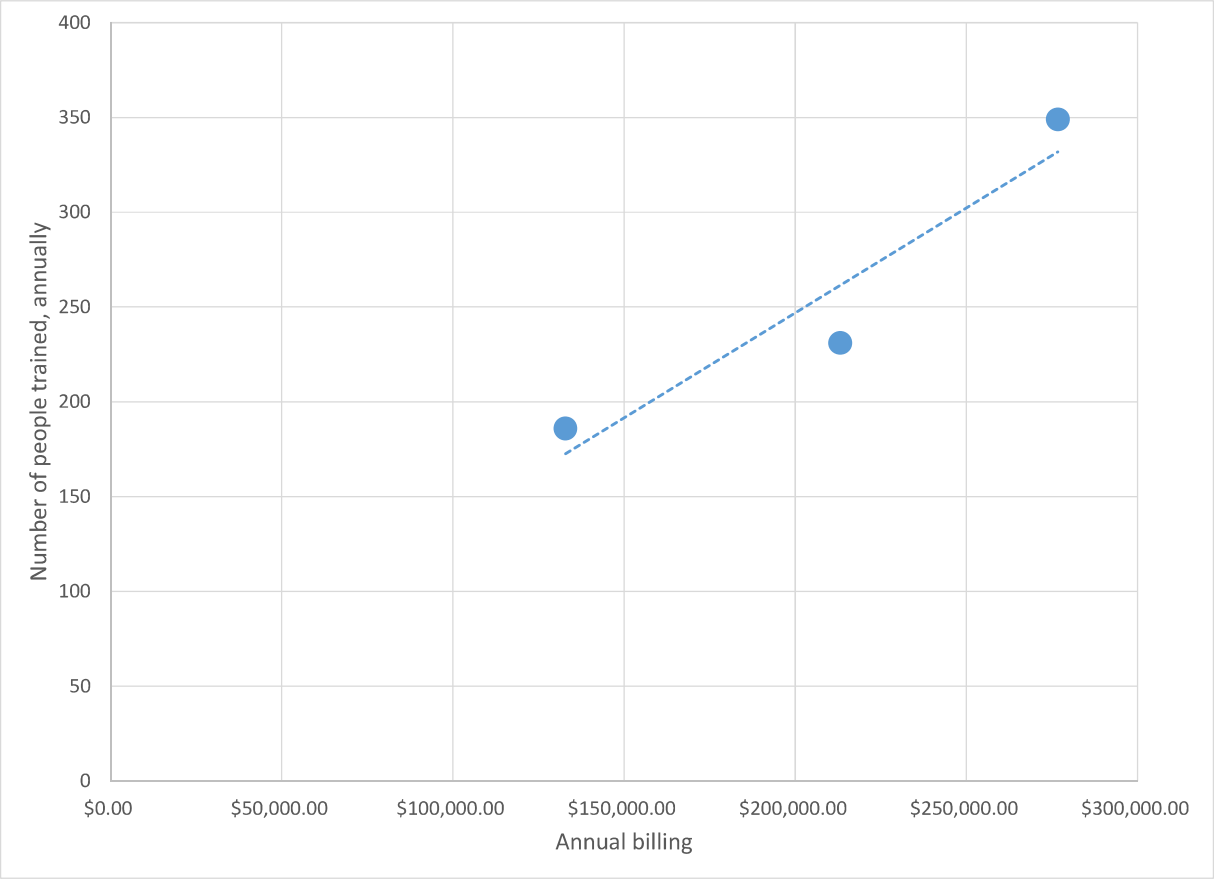


Table 8. Sustainability findings

Evaluation Criteria	Sustainability
Evaluation Questions	1) How are the achieved results, especially the positive changes generated by the project in the lives of women and girls at the project goal level, going to be sustained after this project ends?
Response to the evaluation question with analysis of key findings by the evaluation team	Given evidence that select postprogrammatic exposure measures have steadily improved from their preprogram trajectories, quality measures including documentation of the age of the perpetrator, chief complaint, and whether the survivor bathed are forecasted to continue at 100% for all patients served, which is not the case when using preprogram exposure estimates. If current trends continue, there will be oral swab collection and pubic hair sample collections where there would otherwise be none. Qualitative evidence in Kenya suggests that changes in networking and understanding the roles of other sectors will allow for a more fluid multisector process of evidence transfer, use, and collaboration. Culture change concerning the perception of forensic evidence and the sharing of information was also likely to allow for sustained change beyond the scope of the program. Staff turnover and untrained police in particular could be problematic in the future if not addressed. In DRC, perspectives of other sectors changed among PHR trainees, and an overall greater level of communication between the health care and legal sectors was described. These types of bonds can lead to sustainability if they are reinforced among new colleagues to ensure that training impacts are not lost because of turnover.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	SEMISTRUCTURED INTERVIEW FINDINGS – KENYA *Collaboration between Sectors (S-COL)* Respondents reported not only improved communication with other sectors, but also increasing collaboration on cases and issues of SGBV. New relationships formed between medical providers and police officer, but also lawyers, judges, magistrates, and forensic chemists. While a few doctors reported more limited interactions with legal officials, other respondents described personal, informal relationships growing alongside professional ones. They reported communicating often via phone or a communication app, WhatsApp. Many respondents mentioned that the different sectors had developed a greater understanding of each other's roles, procedures, and pressures. One magistrate stopped issuing arrest warrants for doctors, citing his increased understanding of the demands of their workplace: "I now understand what the policeman goes through. I now understand what the doctor goes through. I understand what the CBOs through. So that I am not making a decision in a rush." Physicians, police officers, chemists, and legal officials all reported cooperating with each other and working together on cases. They described advising each other, responding faster, cooperating as a team, and in some instances forming multisector groups in their community. This increased collaboration was perceived as leading to

	better evidence and investigations, stronger cases, and improved decision making. A magistrate explained: "But now I'm able to have a conversation with a medical doctor on an issue that has come before me and that also assists with the rule now in making a better decision that you'll have made without that information." *Changing Views on Forensic Evidence (S-FE)* After the training, many the interviewed providers and officials changed their opinions about making an effort to document and collect forensic evidence. Respondents reported learning the importance of documentation and evidence collection and their role in building stronger cases for prosecution. They described recognizing the need for specific practice and procedures, such as documenting chain of custody, being detailed, and collecting proper specimens. Some medical providers and police officers found documentation and evidence collection time intensive while others found it relatively simple. However, even those who described the procedures as burdensome reported that it was necessary to ensure justice for survivors. *Changing Response to Cases of Sexual Violence (S-RESP)* A number of respondents reported feeling passionate about addressing issues of sexual violence after the training. Most reported changing their personal response to survivors immediately after the training, although a few said that it took a little bit of time to fully implement new practices. Respondents from all sectors described relating to survivors more personally or with more care after the training. One magistrate reported handling survivors with more sensitivity in court. Medical providers described incorporating these changes into their practices and improving the quality of their care, particularly attending to the psychological needs of survivors. Medical providers and police officers mentioned prioritizing sexual violence cases or responding to them more urgently. Many respondents reported feeling that the change in their response is leading to better outcomes for survivors. *Setbacks Experienced (S-SET)* The largest setback reported by health care providers, forensic chemists, and legal officials was continued resistance from police officers. Although many respondents described positive relationships with the police they trained with, they noted that other officers without the training were difficult to work with on cases. For these reasons, one provider reported relying on a police station with trained officers over those closest to their facility. Respondents wished for more trained police officers or more trained professionals in general. Other providers mentioned more specific setbacks, such as a need for more evidence packaging materials, training with officers who transferred locations, or difficulty serving rural populations. *Transferring Skills (S-TEACH)* Health care providers, police officers, and legal officials reported passing on the knowledge gained in the training. They described advising colleagues, as well as receiving requests for advice. They passed on the knowledge informally as well as training others directly

	or teaching specific skills in filling out forms or collecting evidence. Providers and police officers advised not only colleagues at their level, but also senior officials and supervisors. One clinical officer helped create a protocol to guide other providers, and a nurse in another facility supervised doctors and interns on sexual violence cases. A couple of respondents reported holding other multisector trainings in their areas or trying to educate the general public about addressing sexual violence. One respondent, a nurse, reported speaking at international conferences and receiving requests for PHR training. SEMISTRUCTURED INTERVIEW FINDINGS – DRC *Collaboration between Sectors (S-COL)* Practitioners described many types of collaboration, and improved or developed new relationships with professionals in other sectors. Several respondents reported changing their negative opinions about other sectors. Doctors said that they overcame fears of police, military courts, and judges. Others described moving past criticisms or negative relationships and becoming "allies." Respondents from all sectors reported collaborating with other professionals on cases, particularly on evidence collection. Doctors and police officers worked together to collect evidence, and a police officer mentioned receiving calls from prosecutors checking on evidence. Respondents regularly consult with other sectors, but also reported receiving requests for consultations themselves. One magistrate noted that a hospital not trained by PHR contacted him for help. Several respondents also described working in more formally established networks and groups that sustained relationships formed in trainings. One magistrate attributed survivor's positive outcomes to the work of their network. *Changing Views on Forensic Evidence (S-FE)* Respondents repeatedly described how forensic evidence practices had changed for them personally, for their colleagues, and for other sectors they worked with. They described these differences, not as immediate, but changing over time. Before the training, some doctors had to go to court to explain their evidence, and several respondents acknowledged that poor evidence collection led to dismissals in court cases. After the training, respondents described the importance of forensic evidence to prosecution. One doctor reported trying to think like a doctor and a lawyer after the training, others felt confident that their evidence collection was improving prosecution. Respondents referred to several changed practices, including recognizing the importance of document and evidence storage. Some respondents also reported seeing wider changes and change to the quality of reports and evidence collection in other sectors. A lawyer described seeing changes in police records: "Surely for those who have undergone this training, the records have truly changed, and even their way of placing their requisition has changed…and I am not trying to exaggerate anything but this is the truth. Even you, if you looked at these records you would see the change."

	Changing Response to Cases of Sexual Violence (S-RESP) Respondents from all sectors reported changing their perspective and response to survivors of sexual violence. Practitioners reported feeling more comfortable with survivors and changing their approach to cases. Doctors described handling cases with more sensitivity, and one magistrate acknowledged that he and his colleagues lacked an understanding of oral and anal rape before the training. Many respondents reported improving their communications skills. Doctors changed how they received patients, tried to prevent secondary trauma to victims, and explained procedures to patients. Although one respondent reported changing his response immediately, the rest of the respondents said that their response changed gradually over time or that changes took time to implement. One doctor reported planning short-term and long-term changes after the training. *Setbacks Experienced (S-SET)* While practitioners made many improvements after the training, they also brought up some challenges that they still experienced in their work. Again, respondents mentioned their fears of retribution against themselves and survivors. Respondents also reported a need to have more people trained in all sectors, and one magistrate wanted training for higher-level stakeholders in the judicial system mishandling cases. Several respondents also experienced staff turnover within their own offices and in other sectors. Other specific setbacks mentioned include a lack of technology to manage evidence and the challenges of handling complex needs of survivors. *Transferring Skills (S-TEACH)* While one doctor reported transferring skills from the training to colleagues, three respondents explained how they taught others after the training. A lawyer handling sexual assault cases reported teaching coworkers about many specific sections of the training, including evidence collection, medical reports, and interaction with victims. He said that he routinely advised his coworkers on sexual violence cases. Similarly, a military police officer also trained his colleagues on many skills he gained in the training, and reminding them of proper procedure during cases. He also reported teaching other police units and training other sectors on improving collaboration with law enforcement. A magistrate working in a military court reported recommending PHR training to colleagues, creating enough demand for another PHR training. His office trained employees on proper evidence collection procedures. MEDICAL RECORD FINDINGS Two models were developed for a select subset of outcome variables before and after PHR program exposure periods. Estimates were used to develop forecasts for up to 5 quarters into the future (through March 2016). Before PHR program exposure, medical record quality measures were on a slight downward trajectory for documentation of age of the perpetrator (beta=-0.001, SE=0.005), documentation of the chief complaint (beta=-0.003, SE=0.003), and documentation of

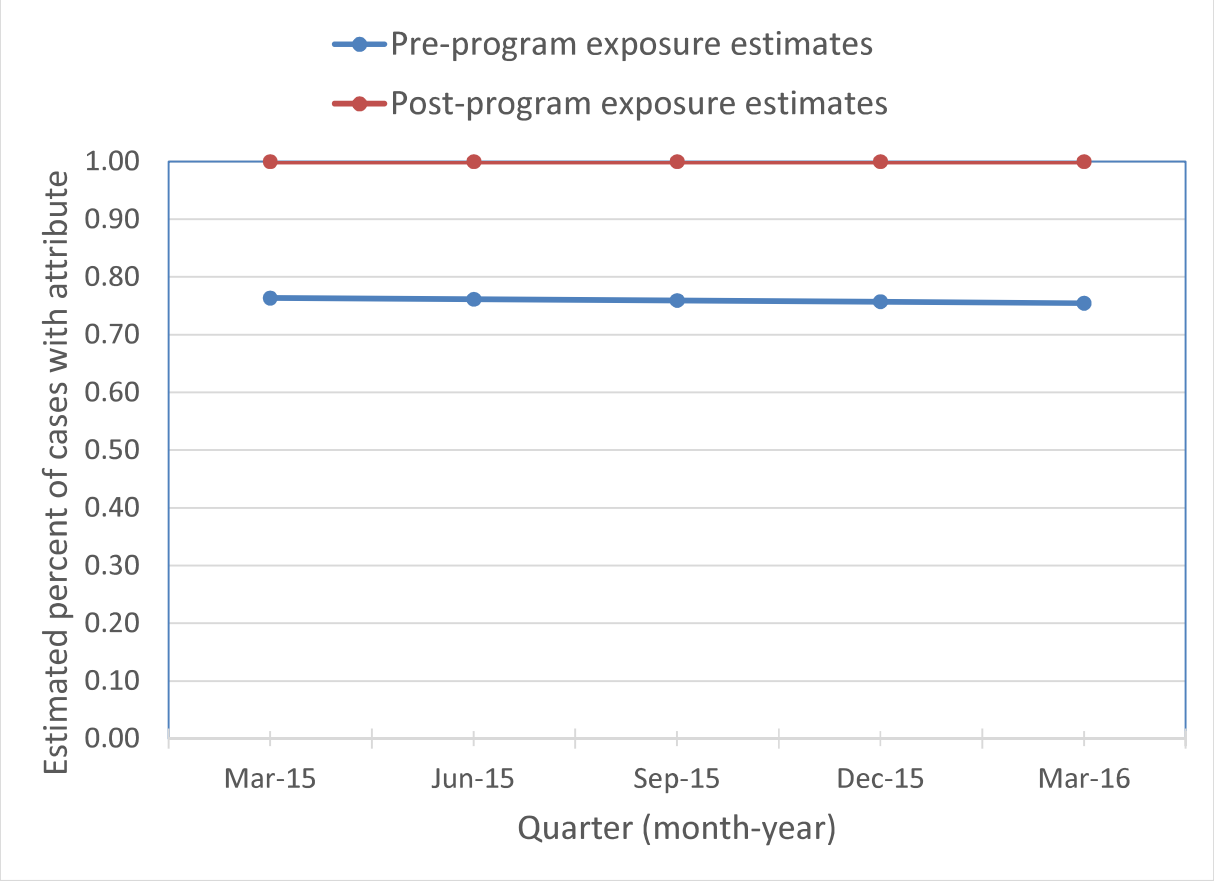
	whether the survivor bathed (beta=-0.00035, SE=0.00038) (Table F). For these items, the postprogram exposure estimates predict 100% documentation by March 2016, which varies notably from the values estimated by the pre-exposure formulas (see figures D, E, and F for scale). In medical evidence collection, there are instances where practices emerged in the postprogram period (oral swab collection, pubic hair sample collection). Assuming postprogram trends, oral swab and pubic hair sample collections will continue to exist (in comparison to not existing at all) at 0.02 and 0.06, respectively (Table F, Figures G and H).
Conclusions	The sustainability of the program depends in part on the multisector collaborations that were built. Medical record forecasts should be interpreted with caution. Prais-Winsten estimates for selected measures compared before and after PHR exposure periods suggest that selected quality and evidence collection measures will continue to exhibit positive trends in survivors' medical records. Qualitative findings show improvements between sectors, in both perception and function. However, these changes may be linked to trained personnel and will likely need to become institutionalized to retain their effect over the long term.
Other	See Table F and Figures D-H below

Table F. Forecast of medical record characteristics using estimates derive from program exposure periods[a]

Medical record characteristic	Program exposure period used to generate the estimate	Prais-Winsten Model Estimates			Forecasted percent of medical records with characteristic[b]				
		Constant	Beta (months)	SE	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16
Age of the perpetrator was documented	Before	0.814	-0.001	0.005	0.76	0.76	0.76	0.76	0.75
	After	0.846	0.002	0.001	1.01	1.02	1.02	1.03	1.04
Chief complaint was documented	Before	0.991	-0.003	0.003	0.80	0.80	0.79	0.78	0.77
	After	0.756	0.004	0.001	1.02	1.03	1.05	1.06	1.07
Whether survivor bathed was documented	Before	1.002	0.000	0.000	0.98	0.98	0.98	0.98	0.97
	After	1.000	0.000	0.000	1.00	1.00	1.00	1.00	1.00
Oral swab was taken	Before	0.010	0.000	0.000	0.00	0.00	0.00	0.00	0.00
	After	0.091	-0.001	0.002	0.03	0.03	0.03	0.02	0.02
Pubic hair sample taken	Before	0.007	0.000	0.000	0.00	-0.01	-0.01	-0.01	-0.01
	After	-0.103	0.002	0.001	0.03	0.04	0.04	0.05	0.06

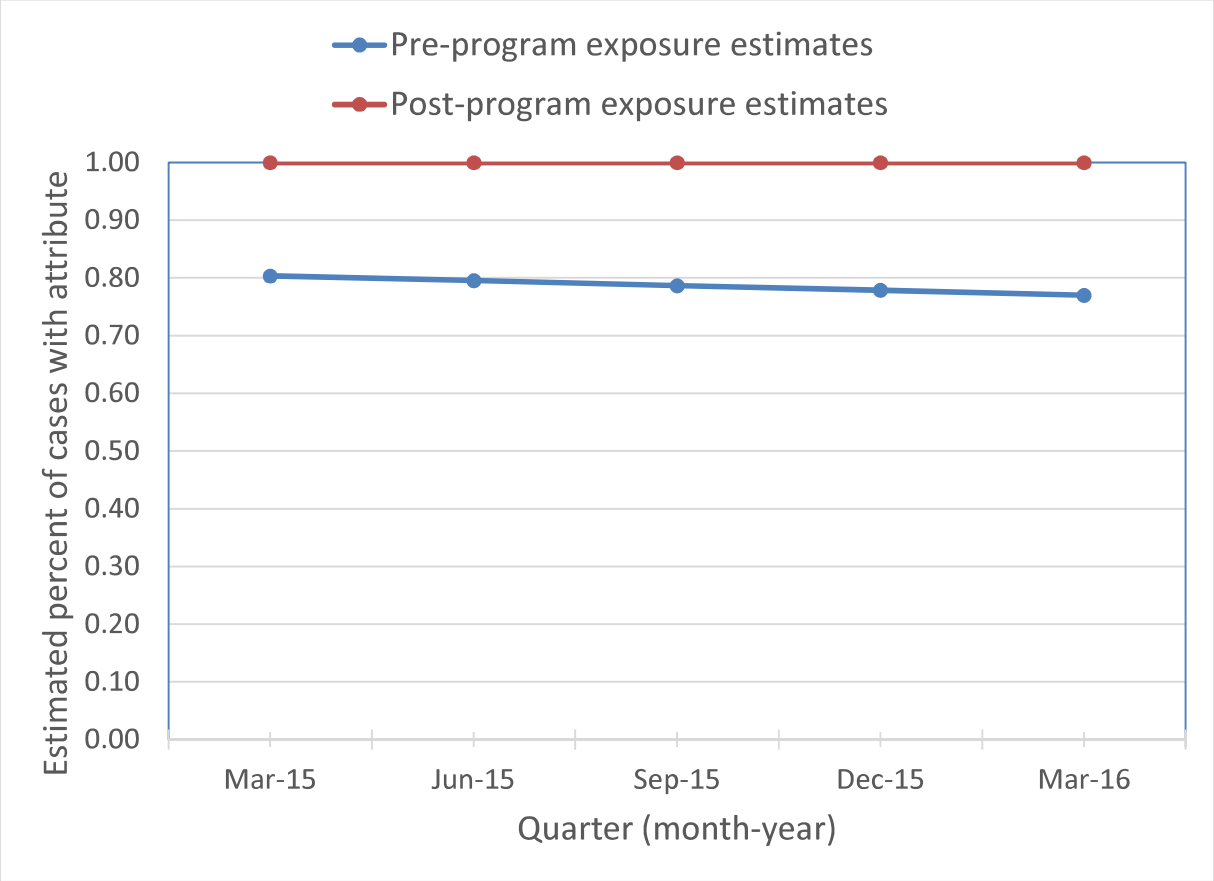
[a]*n=129 pre-exposure months and 72 postexposure months*
[b]*Predicted probability values derived from unadjusted, bivariate Prais-Winsten analyses subset by cases that fell into pre and post PHR program exposure periods*

Figure D. Forecast of documentation of age of perpetrator in medical records, using estimates derived from pre and post program exposure periods*



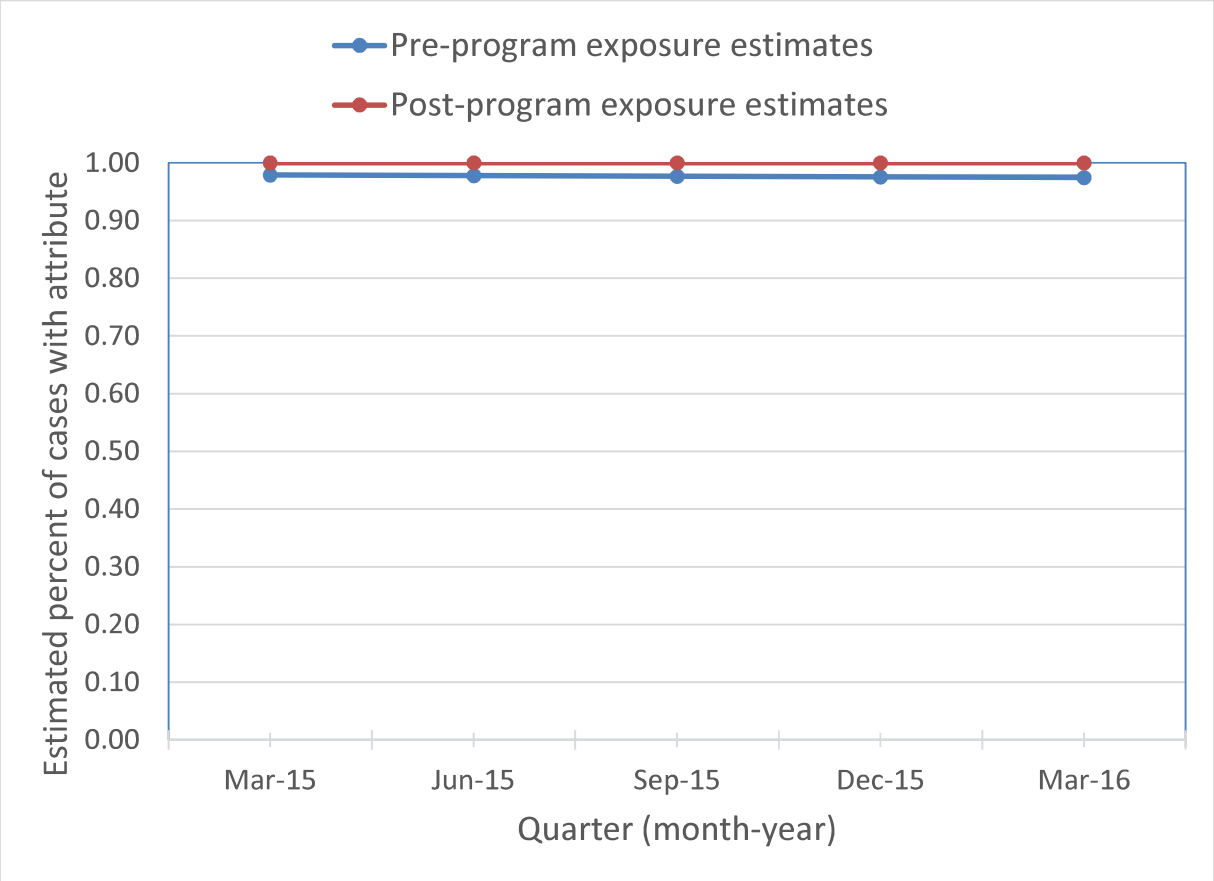
**Predicted probability values derived from unadjusted, bivariate Prais-Winsten analyses subset by cases that fell into pre and post PHR program exposure periods*

Figure E. Forecast of documentation of chief complaint in medical records, using estimates derived from pre and post program exposure periods*



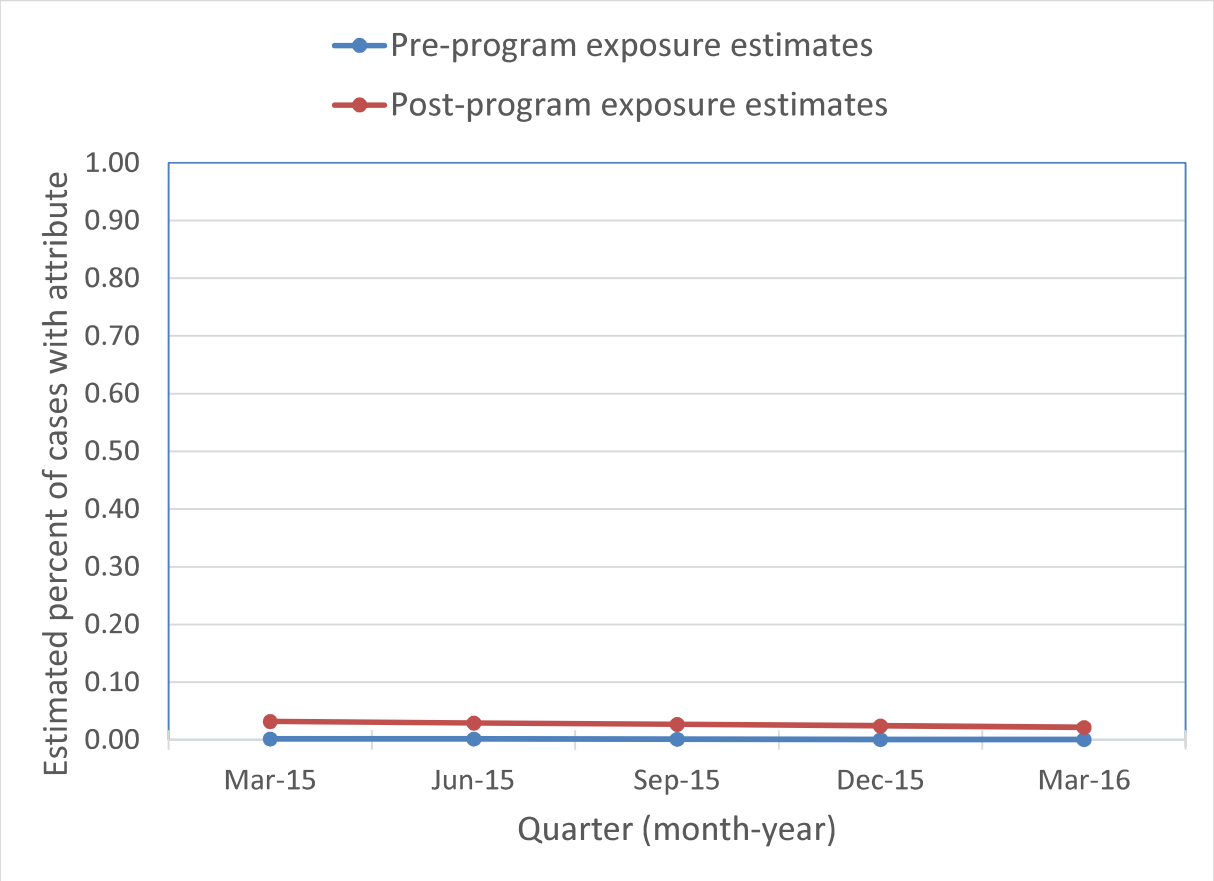
**Predicted probability values derived from unadjusted, bivariate Prais-Winsten analyses subset by cases that fell into pre and post PHR program exposure periods*

Figure F. Forecast of documentation of whether survivor bathed in medical records, using estimates derived from pre and post program exposure periods*



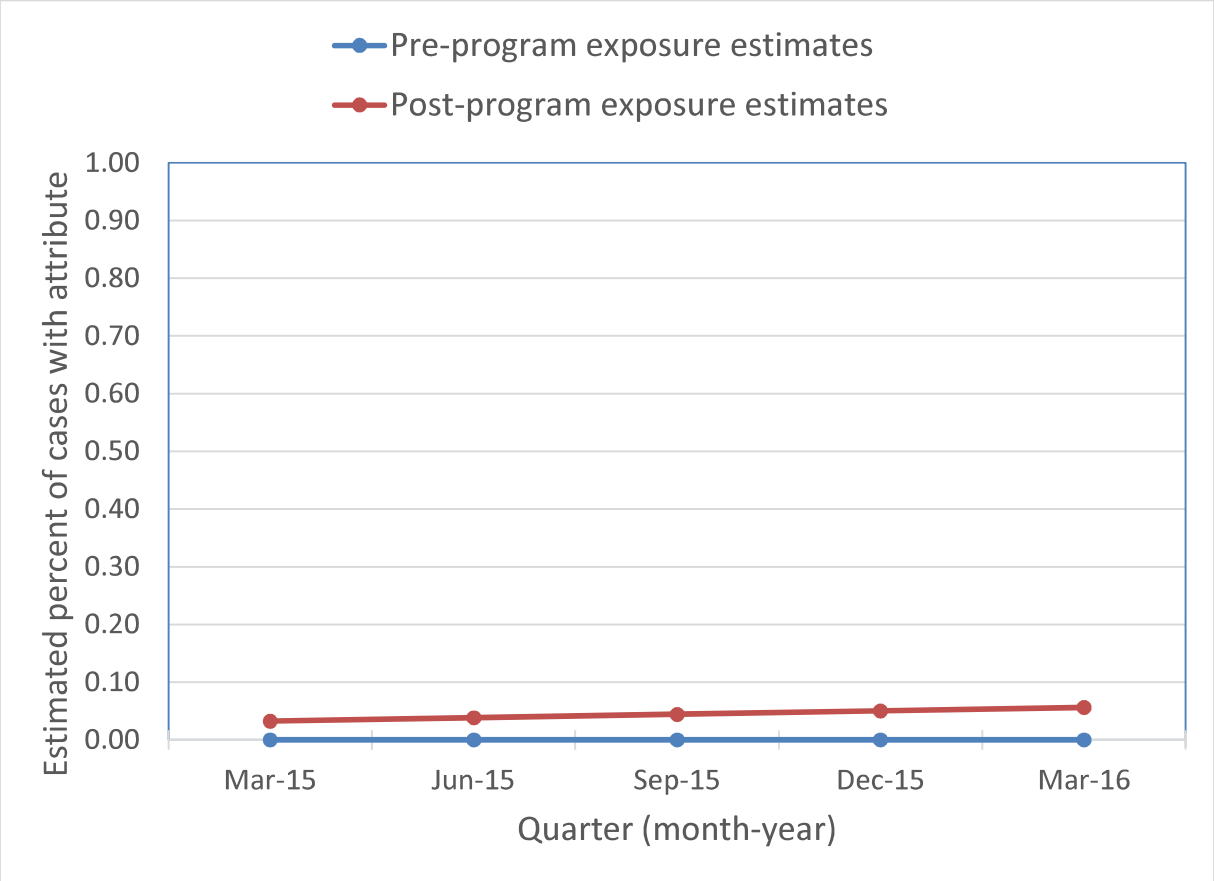
**Predicted probability values derived from unadjusted, bivariate Prais-Winsten analyses subset by cases that fell into pre and post PHR program exposure periods*

Figure G. Forecast of taking oral swabs (in medical records), using estimates derived from pre and post program exposure periods*



**Predicted probability values derived from unadjusted, bivariate Prais-Winsten analyses subset by cases that fell into pre and post PHR program exposure periods*

Figure H. Forecast of taking pubic hair samples (in medical records), using estimates derived from pre and post program exposure periods*



**Predicted probability values derived from unadjusted, bivariate Prais-Winsten analyses subset by cases that fell into pre and post PHR program exposure periods*

Table 9. Impact findings

Evaluation Criteria	Impact
Evaluation Questions	1) What unintended consequences (positive and negative) resulted from the project?
Response to the evaluation question with analysis of key findings by the evaluation team	Changes in medical practice could potentially lead to unobserved changes (positive or negative) at the survivor level. One potential indicator of survivor-level change in behaviour could be observed through temporal patterns in the distance between the date of assault and date of presentation to a health care facility. Although the program did not focus on reducing this gap, it is possible that changes in medical practice may have led to changes in how and why survivors approached health care facilities. Overall, the average number of days between date of assault and date of presentation to a health care facility was reduced. The overall percentage of survivors presenting to a health care facility within three days of the assault increased, but there still remains a need to close this gap. Qualitative interviews in Kenya suggest that this reduction may in part reflect increased trust in health care among survivors. This change may be interpreted as an unintended positive consequence of the PHR program. On the basis of qualitative findings in Kenya, potential negative outcomes included stressors on trainees, as a result of both a lack of institutional readiness for change and the need to reconcile training with current capacity. In DRC, improvements in medical forensic evidence documentation were perceived as contribution to outcomes in the legal sector. Similarly, one unintended consequence included a community complaint regarding too many arrests, although the rise in the arrest rate likely reflects positive changes in capacity.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	MEDICAL RECORD FINDINGS Overall, the average lag in the time between the date of assault and date of presentation to a health care facility. Regression estimates include a 14.7 day reduction in lag in the time period associated with the postprogram exposure period (|z|=1.45, p=0.148). This reduction was -7.2 days in Nakuru (|z|=1.3, p=0.20), -21.2 days in Kisumu (|z|=0.97, p=0.330), and -25.9 days in Minova (|z|=1.1, p=0.268). A gold standard reduction would be reducing the lag period to less than 3 days. Table G shows the percent of cases by location that reported to a health care facility after 3 days. This number was reduced across the board during the postprogram exposure period, except for in Kisumu. The largest effect was observed in Nakuru (0.33 before program exposure, 0.27 after program exposure). SEMISTRUCTURED INTERVIEW FINDINGS- KENYA *Use of Evidence and Testimony (I-EV)* Many of the health care providers interviewed reported clinical data that they collected being used to prosecute and convict perpetrators of sexual violence. Respondents recalled anywhere from three to four cases to over 20. Fewer health care providers reported testifying in court cases. Although some providers, police officers, and a forensic chemist described providing expert testimony for prosecution, others said that their colleagues handled testimony or that

	they had not been called to court. A couple nurses reported feeling equipped to testify if necessary, and a magistrate noted seeing improved expert testimony from medical providers. *Legal Outcomes (I-OUT)* Many providers and officials reported that the evidence or documentation they had provided led to the successful conviction of prosecutors. One doctor described a recent success: "Being keen to document every aspect of the history and looking for the little tiny details on examination has led to…there's a serial offender we managed to get a conviction because we had examined three of the survivors from this particular person. Though they were at different times we could establish a pattern and this helped the prosecution. So I would say it has improved, yes." Some providers reported seeing many convictions after the training, and a magistrate reported having a high conviction rate on sexual assault cases. Other providers were unsure of the outcome of court cases or had many cases still pending in court. Medical providers or police officers did not necessarily track the final outcome of court cases. Providers also described a few cases where perpetrators had gone unpunished or had escaped from prison. In some cases, providers noted that many survivors did not want to pursue legal charges. *Unintended Consequences (I-UN)* While a number of respondents stated seeing no unintended consequences from the training, others reported some different responses coming out of the training, both positive and negative. A few providers described negative reaction or resistance from their organizations, noting that institutional change has been a slow process. Others mentioned capacity issues that came from seeing larger caseloads of sexual violence patients. Some providers described personal fears or worries, such as the possibility of retribution from perpetrators or feeling fatigue from working more sexual violence cases. On the positive side, respondents also reported taking action beyond the core scope of the training. Some worked with committees that created public awareness or education campaigns addressing sexual violence, others began applying skills to other types of violence cases and victims, including male victims of sexual violence. One nurse even began working with perpetrators of sexual violence and giving talks in prisons. *Outcomes for Women and Girls (R-OUT)* Many of the health care providers and police officers interviewed described seeing an increase in reporting or survivors encouraging other women to report and receive treatment for sexual violence. A counselor described the increase at their hospital: "The number of people that we get I think is just a big change because before we were not getting these people we would go out looking for them. We've tried to train the community members, but not many were coming. But today that building is always full. They are very busy, so we feel that something is happening." SEMISTRUCTURED INTERVIEW FINDINGS – DRC

Use of Evidence and Testimony (I-EV)

Respondents reported that courts used evidence they collected in many cases. One doctor was unaware if evidence or reports had been used in court because a colleague followed cases in court. However, all other medical providers reported contributing evidence to legal cases. One provider noted that his evidence had been rejected by courts before the training:

> "Before this training I used not to send because we had not gotten the technique of taking good photos and the photos we used to take would be regarded as not good enough. But now our evidence is seen to be good and it helps them make judgement."

Respondents reported more mixed experiences with testifying in court. While some said that they testified in court both before and after the training, other respondents described being required to testify when their reports needed explanation. After improving reports, they reported being called to explain evidence less often. A lawyer interviewed felt that expert testimony had improved since the training and a magistrate in a military court reported seeing cases moving faster and trusting the evidence submitted in cases.

Legal Outcomes (I-OUT)

Practitioners reported knowing of many cases where their evidence or testimony had helped convict perpetrators. The lawyer reported that he received a conviction in 15 out of 20 cases he could recall. Many respondents attributed increasing convictions to the higher quality of evidence. A military police officer admitted that he used to blame prosecutors for dismissed cases.

> "Before, and I can tell you the truth, in the beginning we were very angry at the fact that you would arrest someone and after some time you find the person freely walking out of there. And so for us we would say that we think the prosecutor has been bribed…Then they would say, 'If you see the kinds of things they write, there is completely no evidence, so how do you jail people without evidence?' Nowadays, when I arrest I look at the evidence I am sending, the evidence goes and you see someone being jailed, he remains in jail, and this is very common these days."

A couple respondents had difficulty following the outcome of court cases because they have to return to their medical duties. Other respondents reported some survivors are not moving forward with cases. A few respondents also mentioned negative case outcomes, describing examples where perpetrators had gone unprosecuted, not given enough jail time, or escaped custody.

Unintended Consequences (I-UN)

Almost all respondents reported seeing only positive outcomes after the training. However, three respondents reported unintended consequences. One circumstance was positive. A doctor reported that his facility had begun sending survivors in rural areas their medical certificates via mail so that they could be used for court. He noted that this was not a technique that PHR taught them, but one that he reported

	as successful. The other two respondents reported negative consequences. One doctor described how the documentation process could be traumatizing to the provider, and a magistrate mentioned receiving complaints from people in the community accusing the courts of arresting too many men.
Conclusions	Positive and negative consequences of the project seem to have occurred most at the community level. An overall reduction in the lag between date of assault and date of presentation to a health care facility was observed in the post-PHR program exposure period and may reflect increased health seeking and system trust among survivors. Trainee stressors may arise from limited resources to implement training material. Community perceptions of increased arrests arose as one problem in one community, and this type of response warrants a need for increased public education and awareness activities.
Other	See table G below

Table G. Cases with a lag period of >3 days (72 hours) between date of assault and date of presentation to a medical facility, relative to PHR program exposure periods[a]

Mean monthly percentage of cases with medical evidence collected, pre and postprogram exposure periods				
	Before program exposure	After program exposure		
	(n=125)[b]	*(n=78)*	*Coef.*	*SE*
Overall	0.43	0.41	-.03	.07
Nakuru	0.33	0.27	-.06	.08
Kisumu	0.35	0.38	.03	0.1
Minova	0.61	0.58	-.03	.14

[a]*Based on 1,136 cases over 69 months*

[b]*Sample sizes vary from presentation statistics given that estimates for these analyses were collapsed based on month of assault versus month of presentation*

**Percentages derived from unadjusted, bivariate Prais-Winsten analyses*

Table 10. Knowledge generation findings

Evaluation Criteria	Knowledge Generation
Evaluation Questions	1) What are the key lessons learned that can be shared with other practitioners on ending violence against women and girls? 2) Are there any promising practices? If yes, what are they and how can these promising practices be replicated in other projects or in other countries that have similar interventions?
Response to the evaluation question with analysis of key findings by the evaluation team	On the basis of qualitative interviews in Kenya, key lessons learned included more engaged trainings that involved hands-on technical training, simulations, the provision of instruments to respondents, and the use of networking to facilitate changes in survivors' experiences with services. Similarly, the need for public outreach has been a continued need expressed by participants, but it is out of scope of the program's logic model. Promising practices include the facilitation of networking activities and the use of a social work navigator to assist sexual assault survivors with the many processes they have to go through. In DRC, promising practices include forensic photography training and providing material during training activities. The need for training expansion and ToT might further distribute program impact. On the basis of medical record findings, the collection of new types of forensic evidence during the medical exam (the collection of oral swabs, pubic hair samples, and other foreign bodies) suggest that future activities that focus on technical practices may readily translate into observable action.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	SEMISTRUCTURED INTERVIEW FINDINGS-KENYA *Lessons and Recommendations (K-REC)* Health care providers, police officers, and legal officials were asked to describe the primary lessons that they have learned and would share with others. Respondents listed a variety of skills and best practices that they implemented after the training. One health care provider described how their facility now uses a social worker to guide patients through the medical and legal processes: "What used to happen is we could examine patients and medically sometimes we forget they're psychologically tortured. So the involvement of a social worker makes sure they've gone through a process, they are taken care of psychologically. And a social worker also makes sure the cases are well followed-up up to the police. Because when there's no social worker involved, basically the cases they just come to hospital for treatment, then they go home and they don't go to the police. They give up on the way, but the involvement of the social worker enables us to make sure that the cases go up to the latter." Medical providers also stressed the importance of communication skills and handling survivors with sensitivity and care. *Key Components of Training (K-TRAIN)* Respondents praised many aspects of the training with PHR. They reported appreciating the focus on evidence collection practices, such as sealing evidence and ensuring chain of custody, as well the

	training on documentation and specific forms. A few providers said that the hands-on technical approach, use of simulations, and provision of instruments were particularly helpful. Other providers listed networking and the multisectoral approach as the best part of the training. One police officer compared the training by PHR to other similar trainings: "We have had other organizations which have been doing the training, but there is no organization that I can compare with PHR because PHR has done the training and give us the materials that we are using which were not there. Other organizations do the training but their training does not involve the practicals. With the PHR they have done a commendable job and a good job that it has really made a positive change in our country." Several respondents praised the overall approach of PHR and found the follow-ups by PHR important for success. *Unmet Needs (K-UM)* The overall response from respondents was positive, but some brought up ongoing needs or requests. Several providers reported seeing a need to educate the general public in order to improve knowledge or change public opinion about sexual violence services. However, providers, police officers, and legal officials most commonly requested more trainings in their country to increase the impact or ongoing training to sustain changes and address staff turnover. Several providers hoped that SGBV training could be incorporated into medical curriculums, police colleges, and judicial education. SEMI-STRUCTURED INTERVIEW FINDINGS – DRC *Lessons and Recommendations (K-REC)* Practitioners and officials had key lessons and recommendations that they said they would pass on to others. Several respondents urged others in their field to do their due diligence in collecting evidence to address sexual violence. Several providers and a police officer recommended that practitioners improve their handling of survivors. One provider wished that those who have not been trained would refer survivors to people with the training and capacity to serve victims. Other respondents wanted to continue meetings with other sectors and training sessions with their colleagues. The lawyer interviewed stressed increasing knowledge of sexual violence and international violence laws. A magistrate recommended the death penalty for perpetrators. *Key Components of Training (K-TRAIN)* Respondents commonly listed documentation, evidence collection, and collaboration as some of the most helpful parts of trainings. Specifically, providers reported learning many skills related to report writing, such as knowing what to document and writing during the patients visit. One doctor, also serving as a medical coordinator, appreciated that PHR helped their team to create a personalized form: "It's not them who did it, but they support the team to do it. That's good. So to support it's kind of sustainable also,

	because we know that it's for us. It's us who work on it, who make it, you see." Respondents also reported learning much about evidence collection from the trainings. Providers described the training in forensic photography and the provision of evidence collection materials as particularly helpful. Respondents commonly praised the collaboration that came from training with other sectors, explaining the multisector training allowed them to learn from other sectors and build relationships. Other respondents praised very specific components of the training such as the pediatric examination training or the hands-on visualizations and anatomical models. *Unmet Needs (K-UM)* Most respondents requested some form of continued training from PHR. Some called for more continuous training, supporting and expanding what they had learned. Others asked that PHR train more people in their sector or expand into underserved rural areas. Several respondents also wanted support from their government to address threats against medical professionals, corruption, and bribery. They also hoped that the government would provide financial support to fund equipment and improved security in DRC. Lastly, a number of practitioners reported seeing a need to educate the public about domestic violence and requested PHR's support. MEDICAL RECORD FINDINGS In Table A of this report, it was observed that previously non-existent practices began taking place in the postprogram exposure period. These practices included the collection of oral swabs, pubic hair samples, and other foreign bodies.
Conclusions	More engaged trainings that involved hands-on technical training, simulations, and the provision of instruments to respondents appear to be helpful components of the PHR training program. Promising practices that were identified include the facilitation of networking activities and the use of a social work navigator to assist sexual assault survivors as they proceed through increasingly communicative sectors. There remains a need for ToT and other sustainability measures, which may be one platform upon which to effect some of these changes in the future. Medical record findings suggest that new medical evidence collection practices were implemented in the postprogram period, although the changes were relatively small.
Other	N/A

2. CONCLUSIONS AND RECOMMENDATIONS

2.1 Conclusions

Table 11. Report conclusions

Evaluation Criteria	Conclusions
Overall	There is evidence to support that the program was able to achieve change within its goal of survivors' benefiting from a survivor-centered approach when receiving services from the health, legal, and law enforcement sectors. The evidence used to examine this impact was based on medical record review findings and qualitative interviews that also supported that change occurred in each of the project's outcome domains. Particular outputs, such as increased knowledge and skills in documentation and professionals' participating in cross-sectoral networks, appeared to play a major role in the project's ability to achieve change within its goal.
Effectiveness	At the outcome level, the project trained 851 personnel across the health care, legal, and law enforcement sectors in Kenya and DRC. Participants had the chance to implement key lessons learned concerning the collection, management, and transfer of sexual assault evidence in support of an estimated 17,448 survivors. Training participants generally perceived an improvement in survivor-centered care, which included attention to confidentiality and the psychological well-being of survivors. Trainees reported changing their practices across sectors specifically concerning the collection and use of forensic evidence, which was also facilitated through trainee participation in multisector networks. Networks that were built across health care, law enforcement, and legal sectors facilitated an improvement in the management and collection of forensic evidence for sexual assault survivors. Concerning the collection of medical evidence, a core focus of the training program, the impact evaluation tested for a change in medical record quality and medical evidence collected relative to PHR exposure periods. This directly tests for an outcome of a change in health care trainee practice. Improvement in the collection of oral swabs was observed across sites after program exposure. It appears that pubic hair and other foreign body sample collections may not have been occurring before the PHR training and that they began on a small scale after the PHR training. Overall, improvements in medical documentation and sample collection translate into improved investigative services that were provided to survivors of sexual assault.
Relevance	The project continued to be relevant to the needs of women and girls. The medical records of female survivors of sexual violence showed evidence of improvement in documentation and evidence collection. The sizeable survivor caseloads in each country, coupled with changes documented in trainee practice, were perceived as effecting changes in communities concerning the reporting of incidents among women and girls.
Efficiency	The program was able to execute training, its core activity, with increased efficiency relative to its originally stated targets.
Sustainability	The sustainability of program activities depends in part on the multisector networks built among training participants, who also use and process

	forensic evidence of sexual assault. Medical record forecasts, which should be interpreted with caution, suggest that select trends in improved documentation quality and evidence collection will generally continue under current conditions. Qualitative findings suggest that relationships between sectors have improved in both perception and function. A continued challenge to sustainability in any training program is reaching a point where a ToT can be effectively conducted and implemented to ensure knowledge transfer within institutions in the absence of external support.
Impact	Positive and negative changes appear to have occurred at the community level. An overall reduction in mean reporting time (between assault and presentation to a health care facility) was associated with the postprogram exposure period in patient medical records. Coupled with selected improvements in medical documentation quality and medical evidence collection, these achievements may have enabled more successful prosecutions. Although trainees in all sectors report attempts to change their practices, trainees may also experience stress when attempting to implement best practices in the context of resource-limited environments.
Knowledge Generation	Concerning training, participants emphasized the usefulness of hands-on technical training, simulations, and the provision of instruments to participants. The program's facilitation of multisector network activities appears to have implications for facilitating implementation of skills learned, providing survivors with more efficiently delivered services. In one site, a social work navigator was established to assist sexual assault survivors with access to services, and this model may be useful in other contexts. Transferring the training material within institutions is a continued need that may best be met with ToT activities.
Others (if any)	N/A

2.2 Key Recommendations

Table 12. Key recommendations

Evaluation Criteria	**Recommendations**	**Relevant Stakeholders** (Recommendation made to whom)	**Suggested timeline** (if relevant)
Overall	Of all recommendations provided below, prioritize sustainability planning.	PHR program staff	4 years after project end
Effectiveness	Ensure that training concerning best practices in medical evidence collected matches what can be locally tested for and feasibly used by the legal sector in each jurisdiction of training	Trainers, program staff	As training locations are identified
Relevance	None	N/A	N/A

Efficiency	Generate internal system that can capture real-time billing for reporting purposes	PHR finance, PHR program staff	N/A
Sustainability	Work with potential trainers (a very small portion of the trainee population) to ensure knowledge transfer within local institutions in the absence of external support. This may take the form of an initial ToT, followed by an apprentice phase and then a monitored phase where the new trainer exhibits the ability to hold the training.	PHR program staff	2–3 years after project end
	Work with local institutions to integrate ToT into local training programs	PHR program staff, Kenyan and Congolese law enforcement training departments	3–4 years after project end
Impact	Close the gap between best practice recommendations in training curricula and current resource restrictions in current work environments. These gaps will vary by training location and sector.	Trainers, program staff	As training locations are identified
Knowledge Generation	Disseminate multisector network building strategy used by the program	PHR program staff, trainers, UNTF	1 year after project end
	Examine the potential of navigation models (e.g., peer navigator, social work navigator) to supplement networking activities	PHR program staff, UNTF	4 years after project end
	The sexual violence program should dedicate PHR program staff labor to monitoring and evaluation coordination, including internal data management, to improve its own monitoring and evaluation efforts	PHR program director	Immediately
Others (if any)	N/A	N/A	N/A

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List of Annexes

1) **Final Version of Terms of Reference (TOR) of the evaluation**
2) **Evaluation matrix**
3) **Beneficiary data sheet**
4) **Methodology-related documentation**
5) **Lists of institutions interviewed or consulted and sites visited**
6) **List of supporting documents reviewed**
7) **CVs of evaluators who conducted the evaluation**

Annex 4: Final version of the Terms of Reference of the evaluation

4.2 Terms of Reference (TOR)

This section of the guidelines is to define the minimum requirements of a Terms of Reference (TOR). It prescribes a structure that all evaluation TORs must follow to ensure its quality.[6]

Note: Each organization may add additional sections as they wish in their TOR. However, the required sections and annexes specified in this guidelines must be provided in the TOR submitted to the UN Trust Fund.

1. Background and Context

1.1 Description of the project that is being evaluated.

a) Name of the project and the organization: Formation of a Medico-Legal Network to Address Sexual Violence in Armed Conflict in Central and Eastern Africa, Physicians for Human Rights
b) Project duration, project start date and end date: 01/09/2011-02/28/2015
c) Current project implementation status with the timeframe to complete the project: The program has been implemented as scheduled and all programmatic activities shall be finalized by the end of grant.
d) Description of the specific forms of violence addressed by the project: The project aims to build capacity and collaborative engagement of local health, legal and law enforcement professionals in their efforts to improve medical evidence for successful prosecutions and convictions of perpetrators of sexual violence in the Democratic Republic of the Congo, Kenya, and Uganda so that perpetrators are held accountable, future crimes can be deterred and women and girls may attain justice including reparations. Additionally, the programme aligns with and will contribute to the Secretary-General's *UNiTE to End Violence Campaign 2008-2015* supporting women
e) Main objectives of the project: PHR and our partners conduct local and regional training workshops and create a Network of local forensic sexual and gender-based violence experts. The programme team performed field assessments, drafted training curricula, moderated discussion forums and employed role-playing exercises as teaching tools while giving technical support for training workshops and intra-Network communication. The project's key objectives are to: 1) training health and legal professionals in forensic skills for prosecutions; 2) forging new alliances between formerly unconnected health and legal actors in support of women and children survivors; 3) helping to achieve a gradual increase of medical evidence and testimonies for prosecutions of perpetrators at local and national levels; and 4) adopting a woman- and girl-centered response across the continuum of the justice system.
f) Description of targeted primary and secondary beneficiaries:
the

Primary Beneficiaries:

The primary beneficiaries of the project are women and girls in conflict and post-conflict zones of the Democratic Republic of the Congo, Kenya, and Uganda. Since the project aims to improve capacities to prosecute, punish and enforce reparation for rape, the cohort of beneficiaries theoretically extends to

[6] The quality criteria are derived from the United Nations Evaluation Group (UNEG) standards (2005), the UN Women Quality Criteria for Evaluation (2009) and the UNDP Handbook on Planning, Monitoring and Evaluating for development results (2009).

potential victims as well as actual survivors in that this initiative is viewed as a prevention measure through the deterrence potential of increased, effective prosecutions. This number is in the millions.

Secondary Beneficiaries:

Secondary beneficiaries include all the professionals in each country who have participated in the training sessions. This group represents 716 doctors, nurses, clinical officers, social workers, police, prosecutors, lawyers, judges, media representatives and NGO advocates who have gained specific technical skills and deeper understandings regarding the development and documentation of forensic evidence of sexual violence. A smaller group of 40 professionals who are mostly in the health sector have benefitted from our Advanced Training modules. These individuals have benefitted from more in-depth training and have developed the ability and opportunities to disseminate training to others in their communities and beyond.

1.2 Strategy and theory of change (or results chain) of the project with the brief description of project goal, outcomes, outputs and key project activities.

Program Description

This project is based on the premise that visible, successful prosecutions and convictions as well as provision of judicial remedies such as court-imposed compensation for victims will deter future crimes. This premise has been endorsed by the UN Special Rapporteur on Violence against Women; by the Special Representative of the Secretary-General; numerous government leaders including US Secretary of State Hillary Rodham Clinton; and by our local colleagues in countries where sexual violence is widespread and systematic. Our medical colleagues from Panzi Hospital in Bukavu, DRC have repeatedly told PHR that unless there is visible and successful prosecution of rape in South Kivu, the crimes will continue to escalate, with the high number of survivors continuing to flood their hospital.

PHR engages with local health and legal professionals by conducting national and regional training workshops and creating networks of forensic SGBV experts. The program team also performed field assessments, drafted training curricula, moderated discussion forums and planned meetings while providing technical support for training workshops and intra-network communication. To demonstrate the most effective ways for health and legal professionals to conduct relationships with survivors and others, this innovative training strategy will involve role-playing exercises as a teaching tool through which all of the stages, from first responder to the judicial process, are dramatized with participants.

In the short term, our program is a response to sexual violence against women and children that have already occurred, with medico-legal alliances created to support prosecutions of those responsible and justice and recovery for survivors.

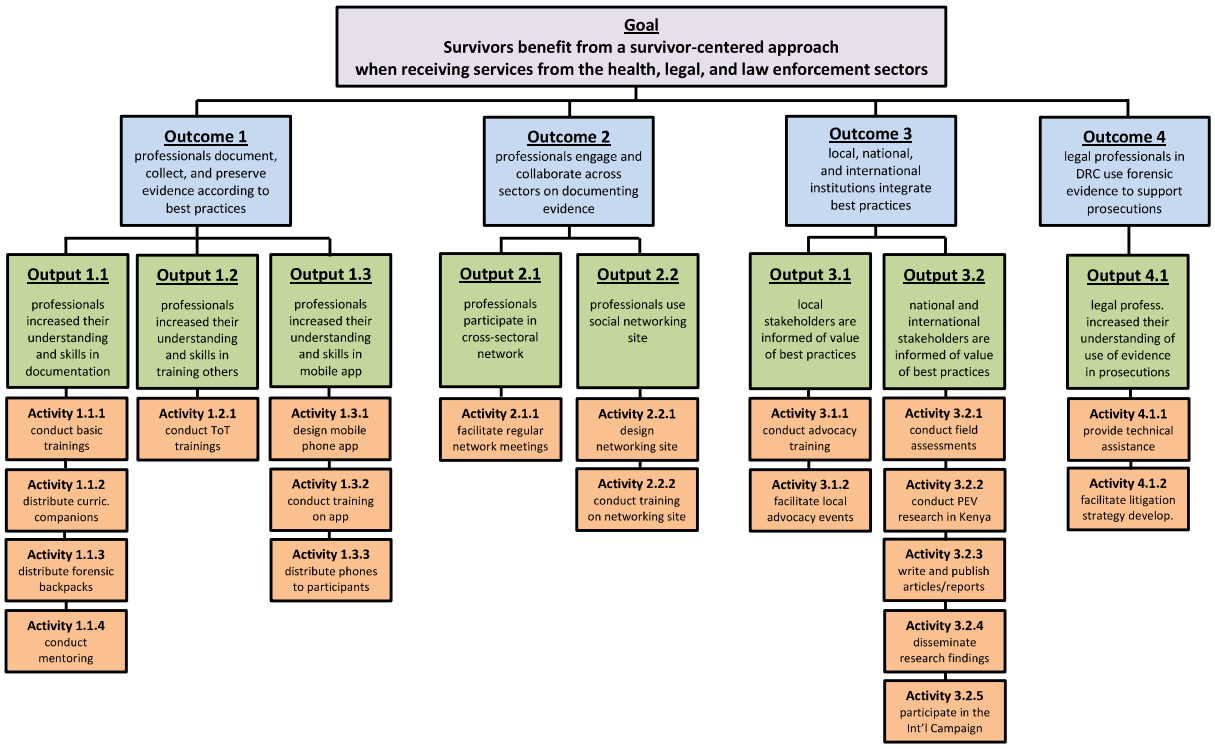
Program Goal

Enhance local and international medical and legal skills and capacities, including medical, investigative, and judicial processes, to ensure greater success for survivors of sexual violence seeking to pursue their cases in national and international courts and to secure accountability for perpetrators of these crimes.

Program Outcomes and Outputs

Figure 1, Program Outcomes and Outputs, below, details the relationships between the program's outcomes and outputs.

Figure 1: Program Outcomes and Outputs



Key Program Activities

Train and mentor health, law enforcement, and legal (including judicial) professionals to effectively, collect, document, analyze, and preserve forensic medical and other evidence to support and strengthen local prosecutions through basic forensic trainings (BT) for cross sectoral cohorts in Kenya and DRC.
Further development of PHR's advanced trainings in Kenya and DRC on forensic photography, pediatric evaluations, documentation on the Post Rape Care (PRC) form in Kenya and the forensic medical certificate in DRC, competency-based trainings on medical evaluations using standardized patients
Develop curriculum for and convene training of trainers (ToT) to build new cohort of certified local trainers in each focus country
Develop innovative mobile technologies to facilitate the collection, documentation and preservation of forensic medial evidence for sexual violence prosecution.
Embed long term consultants to be based on location in country to provide ongoing training and mentorship, as needed
Convene follow up judicial colloquium to train/support judges

1.3 The geographic context, such as the region, country and landscape, and the geographical coverage of this project.

The program currently works in the Democratic Republic of the Congo, Kenya, and Uganda. To date, the program has conducted trainings in the DRC (Goma, Minova, Uvira, Bukavu, and Bunyakiri) and in Kenya (Nairobi, Kisumu, Naivasha, Nakuru and Eldoret). The program will conduct a research project in Uganda.

In light of security concerns due to current active conflict in the Central African Republic and civil war in South Sudan, PHR received approval from the UN Trust to redurect program activities away from these countries.

1.4 Total resources allocated for the intervention, including human resources and budgets (budget need to be disaggregated by the amount funded by the UN Trust Fund and by other sources/donors).

1.5 Key partners involved in the project, including the implementing partners and other key stakeholders.

Physicians for Human Rights, Panzi Hospital- Bukavu, United Nations Development Programme, Kenyatta National Hospital's Gender-based Violence Recovery Centre, and Coalition on Violence Against Women (COVAW), Bukavu General Hospital, HEAL Africa Hospital, Avocats Sans Frontieres, American Bar Association- ROLI, Moi Teaching and Referral Hospital. A detailed list of partner organizations is included in Annex 1.

2. Purpose of the evaluation

2.1 Why the evaluation needs to be done

This is a mandatory final project evaluation required by the UN Trust Fund to End Violence against Women. The current evaluation activities that have been conducted to date focus on the direct outcomes of the program of personnel in the medical, law enforcement, and legal sectors. The evaluation is intended to show impact of the PHR program at the level of survivors of sexual assault. As such, a medical record review will be conducted to capture survivor-level outcomes concerning the collection of forensic evidence from the survivor in the medical sector. To triangulate findings concerning the linkages between sectors that have been built in support of survivors of sexual assault, semistructured qualitative interviews will be conducted with personnel in the medical, law enforcement, and legal sectors.

2.2 How the evaluation results will be used, by whom and when.

The evaluation results will be delivered 2 months following the end of the program. The program's ongoing evaluation efforts have been used previously to inform program development and to refine program quality and strategy. The program will continue beyond the end of the project period, and thus the impact evaluation will be used in a similar manner. The impact evaluation will also be published in a peer-reviewed journal in order to further inform other stakeholders of the results of the evaluation.

2.3 What decisions will be taken after the evaluation is completed

Decisions will be made regarding how the program further focuses its efforts on the collection and processing of forensic evidence in sexual assault cases. This may include refining approaches taken to train physicians, nurses, law enforcement officers, lawyers, and/or judges.

3 Evaluation objectives and scope

3.1 **Scope of Evaluation**:

- Timeframe: This evaluation will cover project activity that began in October 2011 and that was brought to a close in February 2015. Medical records will be retrospectively evaluated to cover pre-project periods (before October 2011) and project periods (October 2011-February 2015).
- Geographical Coverage: This evaluation will cover PHR project activities that took place in the Eastern Democratic Republic of the Congo and in the Rift Valley Region of Kenya. A multistage cluster sampling strategy or a purposive sampling strategy will be used to select medical facilities for inclusion in the medical record review.
- Target groups to be covered: This evaluation will triangulate survivor-level impact through two major units of analysis: 1. The medical records of survivors of sexual assault, and 2. The provider/trainee perceptions of changes in the collection and processing of sexual assault evidence across sectors. The previous qualitative findings that particularly focus on the knowledge and practice of PHR program trainees will also be taken into account in the final report.

3.2 **Objectives of Evaluation**: What are the main objectives that this evaluation must achieve?
The overall objectives of the evaluation are to:

a. Evaluate the entire project in terms of effectiveness, relevance, efficiency, sustainability and impact, with a strong focus on assessing the results at the outcome and project goals;
b. Generate key lessons and identify promising practices for learning;
c. Inform the greater scientific and practitioner communities about the impact of the project.

4 Evaluation Questions

The key questions that need to be answered by this evaluation include the following divided into five categories of analysis. The five overall evaluation criteria – relevance, effectiveness, efficiency, sustainability and impact - will be applied for this evaluation.

Evaluation Criteria	Mandatory Evaluation Questions
Effectiveness	5) To what extent were the intended project goal, outcomes and outputs achieved and how? 6) To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? How many beneficiaries have been reached? 7) To what extent has this project generated positive changes in the lives of targeted (and untargeted) women and girls in relation to the specific forms of violence addressed by this project? Why? What are the key changes in the lives of those women and/or girls? Please describe those changes. 8) What internal and external factors contributed to the achievement and/or failure of the intended project goal, outcomes and outputs? How?

Relevance	3) To what extent was the project strategy and activities implemented relevant in responding to the needs of women and girls? 4) To what extent do achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?
Efficiency	2) How efficiently and timely has this project been implemented and managed in accordance with the Project Document?
Sustainability	2) How are the achieved results, especially the positive changes generated by the project in the lives of women and girls at the project goal level, going to be sustained after this project ends?
Impact	2) What are the unintended consequences (positive and negative) resulted from the project?
Knowledge Generation	3) What are the key lessons learned that can be shared with other practitioners on Ending Violence against Women and Girls? 4) Are there any promising practices? If yes, what are they and how can these promising practices be replicated in other projects and/or in other countries that have similar interventions?

5 Evaluation Methodology

Summary:

Methodological Aspect	Description
1. Proposed evaluation design	Mixed methods research strategy, combining medical record review (quantitative) with semistructured interviews with trainees in the medical, law enforcement, and legal sectors (qualitative)
2. Data sources	Medical records of sexual assault, semistructured interviews with PHR program trainees
3. Proposed data collection methods and analysis	Medical record review with statistical time-series analysis of medical record data (pre/post); semistructured interviews with providers with grounded theoretical approach to analyzing transcripts produced from the interview.
4. Proposed sampling methods	Multi-stage cluster sample / purposive sampling for medical record review, with systematic selection of medical records within each site; purposive sampling strategy for PHR program trainees.
5. Field visits	Data will be collected on-site in the DRC and in Kenya.

Narrative:
For this evaluation, we will use a mixed methods research design to triangulate program impact on survivors of sexual assault. In particular, the evaluation will be focused on the improvements in the collection of medical forensic evidence of sexual assault, and the processing of that evidence between sectors. The two endeavors are described below.

MEDICAL RECORD REVIEW

The PHR program specifically included trainings and technical assistance that addressed examiner knowledge, experience, and technique, with the aim of improving the quality of forensic evidence collected in sexual assault examinations. Medical evidence of sexual assault is likely to vary by injury

definition, examiner training and experience, and examination technique[7]. As such, medical record review can be used to assess whether this variation occurred over time periods corresponding with the implementation of the PHR program.

In this part of the project, we will systematically assess the quality, thoroughness, and documented domains of sexual assault that were recorded over time. Medical record review will be conducted by an on-site team of data collectors who use a standardized form that assesses the medical records under review. Sites will be selected for medical record review using multistage cluster sampling/purposive sampling. Medical records for all patients seen at each of the selected facilities with a diagnosis of sexual violence within a given time period (e.g. January 2009 to February 2015) will be extracted by a study team. Records will be sorted and systematically sampled by year of the record. Quantitative analyses will be conducted to determine whether there were statistically significant changes in medical records between pre and post PHR program periods in quality, thoroughness, and documented domains of sexual assault.

QUALITATIVE INTERVIEWS

While the PHR program focused heavily on improving the quality of medical forensic evidence in sexual assault cases, it also focused on improving survivor-centered care and continuity across the public sectors that provide services to survivors following a sexual assault. This included training personnel from the law enforcement and legal sectors, as well as investing in network building activities to better facilitate the multi-sector processing of forensic evidence. As such, personnel who received training from PHR (physicians, nurses, law enforcement officers, lawyers, and judges) were able to apply their knowledge gained into practice. In the context of this evaluation, they are the closest "social actors" to survivors of sexual assault who can report on how, specifically, forensic evidence of sexual assault was obtained.

A purposive sample of trainees will be selected for participation in a qualitative interview. The interview will be structured to address the effectiveness, relevance, efficiency, sustainability, perceived impact, and knowledge gained from the PHR program. The interview will be audio-recorded and transcribed. Interview subjects will be selected from PHR training participant lists. Interviews will occur in a private location out of earshot range of other individuals. All interviews will be audio-recorded. Interviews will be transcribed and coded using a grounded theoretical framework. Atlas.ti will be used to generate codes for interview data.

6 Evaluation Ethics

The evaluation will be conducted in accordance with the principles outlined in the UN Evaluation Group (UNEG) 'Ethical Guidelines for Evaluation' http://www.unevaluation.org/ethicalguidelines. The evaluator(s) will consult with the relevant documents as relevant prior to development and finalization of data collection methods and instruments:

- World Health Organization (2003). *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women*. www.who.int/gender/documents/violence/who_fch_gwh_01.1/en/index.html
- Jewkes, R., E. Dartnall and Y. Sikweyiya (2012). *Ethical and Safety Recommendations for Research on the Perpetration of Sexual Violence*. Sexual Violence Research Initiative. Pretoria,

[7] Sugar NF, Fine DN, Eckert LO (2004) Physical injury after sexual assault: findings of a large case series. Am J Obstet Gynecol 190: 71–76

South Africa, Medical Research Council. Available from www.svri.org/EthicalRecommendations.pdf

- Researching violence against women: A practical guide for researchers and activists November 2005 http://www.path.org/publications/files/GBV_rvaw_complete.pdf
- World Health Organization (WHO), 'Ethical and safety recommendations for researching documenting and monitoring sexual violence in emergencies' 2007, http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

The impact evaluation protocol will be submitted for review to the RTI IRB. Below are a list of special considerations regarding both of the research methods that will be used to conduct the impact evaluation.

CONSIDERATIONS REGARDING MEDICAL RECORD REVIEW

RTI plans to examine records abstracted from medical centers in Kenya and the Democratic Republic of the Congo to determine temporal trends and patterns in sexual violence cases occurring within a given time period (e.g. from January 2009 to February 2015). This study is a retrospective study of sexual violence cases presenting to the clinic, hospital, or site. We will examine the frequency and patterns of sexual violence in de-identified case records that have been extracted onto a data collection form. Because of the many years of data that will be collected, we will be able to describe the temporal trends in sexual violence cases, and to determine the quality and completeness of the medical record associated with specific time periods.

There is only a minimal, remote risk of identification of subjects. This analysis involves collection and analysis of data derived from archival review. Data elements that are extracted from the medical record will be coded according to the order in which they appear, however no linking identifier back to the patient record will be produced. The electronic database will be maintained on a password-protected computer by the Principal Investigator, and a random number will be assigned to each record in the analytic database such that if an individual were to ever gain access to the analytic database, it would not be possible to link records with individual patients. The analytic database will be shared only with necessary members of the study team. Only members of the data collection team will have access to paper records. Records reviewed will be entered into the matrix database. The analytic database will then be used to conduct analyses.

CONSIDERATIONS REGARDING SEMISTRUCTURED INTERVIEWS

Semistructured interview participants will be asked to verbally consent to the interview. The interviewer will be asked to initial each key paragraph of the consent statement in order to ensure that the elements of consent have been covered. The verbal consent forms will include a description of the organizations involved in the study, a description of the interview, risks and benefits of the interview, time involvement, compensation, rights, and contacts for follow-up.

We will recruit PHR program training participants (healthcare, law enforcement, and legal professionals) to participate in semistructured interviews as part of the project outcomes evaluation.

We will recruit individuals to participate in the interviews form the population of individuals trained by the PHR Program on Sexual Violence in Conflict Zones. All training program participants will be asked to participate in a follow-up one hour interview with a member of the research team. If subjects cannot communicate comfortably in English, we will use simultaneous translation to interview subjects. The translator will be an individual who is independent from the PHR program and from the profession of the trainees involved, and who will be experienced in conducting interviews where sensitivity of the information discussed may be of concern. We estimate that we will recruit

approximately 10-20 trainees per country, recruiting and interviewing trainees until thematic saturation is achieved. Prior to each interview, individuals will be asked to provide their verbal consent. All interviews will be conducted in private, closed offices, spaces, or locations out of earshot range in which their privacy will be assured. We will then use a semistructured interview guide to pose questions to subjects regarding their professional practices regarding management of cases of sexual violence, multi-sector collaboration, and incorporation of knowledge and best practices derived from training into professional practices. Data will be audio-recorded and stored on a SD chip that will be with the researcher during all times in the field. The SD chip will be used to extract audio recordings, which will be transcribed and destroyed. Transcription files will be de-identified and any information provided by the participant that could link to that individual's identity will be changed or removed from the transcript. All technical reports and/or publications emerging from the semistructured interview activity will be redacted accordingly to protect subjects' identity if a quote is used.

7 Key deliverables of evaluators and timeframe

	Deliverables	Description of Expected Deliverables	Timeline of each deliverable (date/month/year)
1	**Evaluation inception report** (language of report: English)	The inception report provides the grantee organization and the evaluators with an opportunity to verify that they share the same understanding about the evaluation and clarify any misunderstanding at the outset. An inception report must be prepared by the evaluators before going into the technical mission and full data collection stage. It must detail the evaluators' understanding of what is being evaluated and why, showing how each evaluation question will be answered by way of: proposed methods, proposed sources of data and data collection/analysis procedures. The inception report must include a proposed schedule of tasks, activities and deliverables, designating a team member with the lead responsibility for each task or product. The structure must be in line with the suggested structure of the annex of TOR.	12/01/14
2	**Draft evaluation report** (language of report: English)	Evaluators must submit draft report for review and comments by all parties involved. The report needs to meet the minimum requirements specified in the annex of TOR. The grantee and key stakeholders in the evaluation must review the draft evaluation report to ensure that the evaluation meets the required quality criteria.	01/04/2015

3	**Final evaluation report** (language of report: English)	Relevant comments from key stakeholders must be well integrated in the final version, and the final report must meet the minimum requirements specified in the annex of TOR. The final report must be disseminated widely to the relevant stakeholders and the general public.	01/05/2015

8 Evaluation team composition and required competencies

8.1 Evaluation Team Composition and Roles and Responsibilities

The Evaluation Team will be consisting of 2 international consultant(s) and 3 national consultant(s).

Evaluator A: Dr. Mike Anastario Research Sociologist at RTI International will be responsible for undertaking the evaluation from start to finish and for managing the evaluation team under the supervision of evaluation task manager from the grantee organization, for the data collection and analysis, as well as report drafting and finalization in English.

Evaluator B: Ms. Kelle Barrick, Research Criminologist at RTI International's Center for Justice, Safetly, and Resillience will assist Dr. Anastario to undertaking the evaluation from start to finish and for managing the evaluation team under the supervision of evaluation task manager from the grantee organization, for the data collection and analysis, as well as report drafting and finalization in English

Consultants (3) will work with the Evaluators to assist with on-the-ground data collection, logistics, and translation of data from local languages (where applicable) to English.

8.2 Required Competencies

International Staff

Evaluator A

- Evaluation experience at least 8 year in conducting external evaluations, with mixed-methods evaluation skills and having flexibility in using non-traditional and innovative evaluation methods
- Expertise in gender and human-rights based approaches to evaluation and issues of violence against women and girls
- Specific evaluation experiences in the areas of ending violence against women and girls
- Experience in collecting and analysing quantitative and qualitative data
- In-depth knowledge of gender equality and women's empowerment
- A strong commitment to delivering timely and high-quality results, i.e. credible evaluation and its report that can be used
- A strong team leadership and management track record, as well as interpersonal and communication skills to help ensure that the evaluation is understood and used.
- Good communication skills and ability to communicate with various stakeholders and to express concisely and clearly ideas and concepts
- Regional/Country experience and knowledge: in-depth knowledge of Kenya and the Democratic Republic of the Congo is required.

- Language proficiency: fluency in English is mandatory; good command of local language French and/or Kiswahili is desirable.

Evaluator B

- Evaluation experience of at least 8 year in conducting external evaluations, with mixed-methods evaluation skills and having flexibility in using non-traditional and innovative evaluation methods
- Expertise in gender and human-rights based approaches to evaluation and issues of violence against women and girls
- Specific evaluation experiences in the areas of ending violence against women and girls
- Experience in collecting and analysing quantitative and qualitative data
- In-depth knowledge of gender equality and women's empowerment
- A strong commitment to delivering timely and high-quality results, i.e. credible evaluation and its report that can be used
- A strong team leadership and management track record, as well as interpersonal and communication skills to help ensure that the evaluation is understood and used.
- Good communication skills and ability to communicate with various stakeholders and to express concisely and clearly ideas and concepts
- Regional/Country experience and knowledge: in-depth knowledge of Kenya and the Democratic Republic of the Congo is required.
- Language proficiency: fluency in English is mandatory; good command of local language French and/or Kiswahili is desirable.

National Staff
Consultants (3)

- Research coordination and collection experience of at least 5 years in working with international evaluations and/ or research studies
- Familiariaty with gender and human-rights based approaches to evaluation and issues of violence against women and girls
- A strong commitment to delivering timely and high-quality results, i.e. credible evaluation and its report that can be used
- Good communication skills and ability to communicate with various stakeholders and to express concisely and clearly ideas and concepts
- Regional/Country experience and knowledge: in-depth knowledge of Kenya and the Democratic Republic of the Congo is required.
- Language proficiency: fluency in English and Kiswahili (or other appropriate local languages) is mandatory; good command of local language French is desirable.

9 Management Arrangement of the evaluation

Name of Group	Role and responsibilities	Actual name of staff responsible

Evaluation Team	External evaluators/consultants to conduct an external evaluation based on the contractual agreement and the Terms of Reference, and under the day-to-day supervision of the Evaluation Task Manager.	External evaluators
Evaluation Task Manager	Someone from the grantee organization, such as project manager and/or M&E officer to manage the entire evaluation process under the overall guidance of the senior management, to: • lead the development and finalization of the evaluation TOR in consultation with key stakeholders and the senior management; • manage the recruitment of the external evaluators; • lead the collection of the key documents and data to be share with the evaluators at the beginning of the inception stage; • liaise and coordinate with the evaluation team, the reference group, the commissioning organization and the advisory group throughout the process to ensure effective communication and collaboration; • provide administrative and substantive technical support to the evaluation team and work closely with the evaluation team throughout the evaluation; • lead the dissemination of the report and follow-up activities after finalization of the report	Tom McHale, Program Officer, Program on Sexual Violence in Conflict Zones
Commissioning Organization	Senior management of the organization who commissions the evaluation (grantee) – responsible for: 1) allocating adequate human and financial resources for the evaluation; 2) guiding the evaluation manager; 3) preparing responses to the recommendations generated by the evaluation.	Karen Naimer, Director, Program on Sexual Violence in Conflict Zones
Reference Group	Include primary and secondary beneficiaries, partners and stakeholders of the project who provide necessary information to the evaluation team and to reviews the draft report for quality assurance	Primary beneficiaries include survivors who sexual violence who receive services from first responders being trained. Secondary beneficiaries include law enforcement, judicial officials, and medical professionals who directly participated in the training program.

Advisory Group	Must include a focal point from the UN Women Regional Office and the UN Trust Fund Portfolio Manager to review and comment on the draft TOR and the draft report for quality assurance and provide technical support if needed.	Veronica Zebadua Yanez, Program Specialist, Farida Deif, Deputy Manager

10 Timeline of the entire evaluation process

Stage of Evaluation	**Key Task**	**Responsible**	**Number of working days required**	**Timeframe** (dd/mm/yyyy - dd/mm/yyyy)
Preparation stage	Prepare and finalize the TOR with key stakeholders	Commissioning organization and evaluation task manager	10	26/11/2014-19/12/2014
	Compiling key documents and existing data		1	17/12/2014
	Recruitment of external evaluator(s)		1	26/11/2014
Inception stage	Briefings of evaluators to orient the evaluators	evaluation task manager	2	01/12/2014-15/01/2015
	Desk review of key documents	Evaluation Team	3	01/12/2015-15/01/2015
	Finalizing the evaluation design and methods	Evaluation Team	3	01/12/2015-15/01/2015
	Preparing an **inception report**	Evaluation Team	0	N/A
	Review Inception Report and provide feedback	Evaluation Task Manager, Reference Group and Advisory Group	0	N/A
	Submitting final version of **inception report**	Evaluation Team	0	N/A

Data collection and analysis stage	Desk research	Evaluation Team	10	09/12/2014-16/01/2015
	In-country technical mission for data collection (visits to the field, interviews, questionnaires, etc.)	Evaluation Team	**15**	**26/01/2015-27/02/2015**
Synthesis and reporting stage	Analysis and interpretation of findings	Evaluation Team	20	27/02/2015-27/03/2015
	Preparing a **draft report**	Evaluation Team	15	27/03/2015-17/04/2015
	Review of the draft report with key stakeholders for quality assurance	Evaluation Task Manager, Reference Group, Commissioning Organization Senior Management, and Advisory Group	10	18/04/2015-02/05/2015
	Consolidate comments from all the groups and submit the consolidated comments to evaluation team	Evaluation Task Manger	5	03/05/15-09/05/15
	Incorporating comments and revising the evaluation report	Evaluation Team	5	09/05/15-16/05/15
	Submission of the **final report**	Evaluation Team	5	05/17/15-05/24/15
	Final review and approval of report	Evaluation Task Manager, Reference Group, Commissioning Organization Senior Management, and Advisory Group	7	05/24/15-05/31/15
Dissemination and follow-up	Publishing and distributing the final report	commissioning organization led by evaluation manager	30	01/06/15-30/06/15
	Prepare management responses to the key recommendations of the report	Senior Management of commissioning organization	14	01/07/15-15/07/15
	Organize learning events (to discuss key findings and recommendations, use the finding for planning of following year, etc)	commissioning organization	30	16/07/15-15/08/15

11 Budget

12 Annexes

1) **Key stakeholders and partners to be consulted**
2) **Documents to be consulted**
3) **Required structure for the inception report**
4) **Required structure for the evaluation report**

2.3

Annex 1

Key Stakeholders and Partners to be Consulted

Country	Sector	Name
Dem. Republic of the Congo	Medical	Panzi Hospital
Dem. Republic of the Congo	Medical	Bukavu General Hospital
Dem. Republic of the Congo	Medical	Minova General Hospital
Dem. Republic of the Congo	Medical	Uvira General Hospital
Dem. Republic of the Congo	Medical	HEAL Africa
Dem. Republic of the Congo	Legal	Avocats Sans Frontieres
Dem. Republic of the Congo	Legal	American Bar Association- ROLI
Dem. Republic of the Congo	Police	GBV Unit of Bukavu
Dem. Republic of the Congo	United Nations	UNDP- DRC
Dem. Republic of the Congo	United Nations	UNFPA-DRC
Dem. Republic of the Congo	United Nations	MONUSCO
Kenya	Medical	Kenya National Hospital (Gender-based Violence Recovery Centre)
Kenya	Medical	Nairobi Women's Hospital
Kenya	Medical	Mama Lucy Kibaki Hospital
Kenya	Medical	Moi Teaching and Referral Hospital (Eldoret)
Kenya	Medical	Nakuru Provincial General Hospital
Kenya	Medical	Naivasha District Hospital
Kenya	Legal	Kisumu Law Courts

Kenya	Legal	Legal Aid Centre Eldoret (LACE)
Kenya	Police	Kenya Police Service
Kenya	Legal	COVAW
Kenya	Legal	ICJ-Kenya
Kenya	NGO/CSO	Wangu Kanja Foundation
Global	NGO	Nobel Women's Initative
Kenya	NGO	ICTJ-Kenya
Global	NGO	Insitutute for Historical Jusice and Reconciliation
USA	Academia	Columbia Univeristy School of Interational Public Affairs
USA	Academia	Brandeis University Institute for Interational Judges

Annex 2

Documents to be Consulted

Relevant national strategy documents

Kenya Ministry of Public Health National Guidelines on Management of Sexualiolence in Kenya, 2009

WHO. 2005. WHO Multi-Country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses. Geneva, Switzerland, WHO.

Sexual Offenses Act, Kenya, 2006

Congolese Legal Code

Program Strategic and other planning documents

Baseline data of the project (i.e. Results Monitoring Plan and Baseline Report)

Monitoring plans, indicators and summary of monitoring data

2011, 2012, 2013, 2014 Progress and annual reports of the project

Academic Resources

Anastario MP, Adhiambo Onyango M, Nyanyuki J, Naimer K, Muthoga R, et al. (2014) Time Series Analysis of Sexual Assault Case Characteristics and the 2007–2008 Period of Post-Election Violence in Kenya. PLoS ONE 9(8)

Dahrendorf N, Shifman P (2004) Sexual violence in conflict and post-conflict: A need for more focused action. Refugee Survey Quarterly 23

Agirre Aranburu X (2010) Sexual Violence beyond Reasonable Doubt: Using Pattern Evidence and Analysis for International Cases. Leiden Journal of International Law 23

Schissel B (1996) Law reform and social change: A time-series analysis of sexual assault in anada. Journal of Criminal Justice 24

International Criminal Court (2012). Summary of decision in the two Kenya cases. International Criminal Court. 23 January 2012. Available: http://www.icc-cpi.int/NR/exeres/7036023F-C83C-484E-FDD-0DD37E568E84.htm.

Kuria MW, Omondi L, Olando Y, Makanyengo M, Bukusi D (2013) Is sexual abuse a part of war? A 4-year retrospective study on cases of sexual abuse at the Kenyatta National Hospital Kenya. 4.

Tsai AC, Eisa MA, Crosby SS, Sirkin S, Heisler M, et al. (2012) Medical evidence of human rights violations against non-Arabic-speaking civilians in Darfur: a cross-sectional study. PLoS Med 9

Ingemann-Hansen O, Brink O, Sabroe S, Sorensen V, Charles AV (2008) Legal aspects of sexual violence–does forensic evidence make a difference? Forensic Sci Int 180:

Janisch S, Meyer H, Germerott T, Albrecht UV, Schulz Y, et al. (2010) Analysis of clinical forensic examination reports on sexual assault. Int J Legal Med 124

Bouffard JA (2000) Predicting type of sexual assault case closure from victim, suspect, and case characteristics. Journal of Criminal Justice 28

McGregor MJ, Du Mont J, Myhr TL (2002) Sexual assault forensic medical examination: is evidence related to successful prosecution? Ann Emerg Med 39

(2008) Report of the Findings of the Commission of Inquiry into the Post-Election Violence in Kenya.

Bartels SA, Scott JA, Leaning J, Kelly JT, Joyce NR, et al. (2012) Demographics and care-seeking behaviors of sexual violence survivors in South Kivu province, Democratic Republic of Congo. Disaster Med Public Health Prep 6

Annex 3
Required Structure of the Inception Report

In lieu of an inception report, PHR and RTI have engaged in a collaborative process of planning the study. This is meant to foster close collaboration and communication between the organizations with the goal of building deep and meaningful relationships between the organizations in the spirit of close partnership. As such, close and coordinated cooperation in the TOR development process has taken the place of a formal inception report, with the approval of the UN Trust Fund.

Annex 4
Required Structure of Evaluation Report

1. **Title and cover page**
    - Name of the project
    - Locations of the evaluation conducted (country, region)
    - Period of the project covered by the evaluation (month/year – month/year)
    - Date of the final evaluation report (month/year)
    - Name and organization of the evaluators
    - Name of the organization(s) that commissioned the evaluation
    - Logo of the grantee and of the UN Trust Fund

2. **Table of Content**

3. **List of acronyms and abbreviations**

4. **Executive summary**
    - Brief description of the context and the project being evaluated;
    - Purpose and objectives of evaluation;
    - Intended audience;
    - Short description of methodology, including rationale for choice of methodology, data sources used, data collection & analysis methods used, and major limitations;
    - Most important findings with concrete evidence and conclusions; and
    - Key recommendations.

5. **Context of the project**
    - Description of critical social, economic, political, geographic and demographic factors within which the project operated.
    - An explanation of how social, political, demographic and/or institutional context contributes to the utility and accuracy of the evaluation.

6. **Description of the project**
    - Project duration, project start date and end date
    - Description of the specific forms of violence addressed by the project
    - Main objectives of the project
    - Importance, scope and scale of the project, including geographic coverage
    - Strategy and theory of change (or results chain) of the project with the brief description of project goal, outcomes, outputs and key project activities
    - Key assumptions of the project
    - Description of targeted primary and secondary beneficiaries as well as key implementing partners and stakeholders
    - Budget and expenditure of the project

7. **Purpose of the evaluation**
    - Why the evaluation is being done
    - How the results of the evaluation will be used

- What decisions will be taken after the evaluation is completed
- The context of the evaluation is described to provide an understanding of the setting in which the evaluation took place

8. Evaluation objectives and scope

- A clear explanation of the objectives and scope of the evaluation.
- Key challenges and limits of the evaluation are acknowledged and described.

9. Evaluation Team

- Brief description of evaluation team
- Brief description of each member's roles and responsibilities in the evaluation
- Brief description of work plan of evaluation team with the specific timeline and deliverables

10. Evaluation Questions

- The original evaluation questions from the evaluation TOR are listed and explained, as well as those that were added during the evaluation (if any).
- A brief explanation of the evaluation criteria used (e.g. relevance, efficiency, effectiveness, sustainability and impact) is provided.

11. Evaluation Methodology

[The template below must be used for this section.]

Sub-sections	Inputs by the evaluator(s)
Description of evaluation design	*[please specify if the evaluation was conducted by one of the following designs: 1) post-test[8] only without comparison group; 2) pre-test and post-test without comparison group; 3) pre-test and post-test with comparison group; or 4) randomized control trial.]*
Data sources	
Description of data collection methods and analysis (including level of precision required for quantitative methods, value scales or coding used for qualitative analysis; level of participation of stakeholders through evaluation process, etc.)	[Please refer to the evaluation matrix (template Annex 4A)
Description of sampling • Area and population to be represented • Rationale for selection • Mechanics of selection limitations to sample • Rreference indicators and benchmarks/baseline, where relevant (previous indicators, national statistics, human rights	

[8] "Test" means project/intervention in this context.

treaties, gender statistics, etc.)	
Description of ethical considerations in the evaluation • Actions taken to ensure the safety of respondents and research team • Referral to local services or sources of support • Confidentiality and anonymity protocols • Protocols for research on children, if required.	
Limitations of the evaluation methodology used	

12. Findings and Analysis per Evaluation Question

[The template below must be used per evaluation question in order to provide direct answer to the question, key findings and analysis, and quantitative and qualitative evidence per evaluation question. Evaluators may add additional paragraphs/sub-sections in narrative format to describe overall findings and analysis if they wish.]

Evaluation Criteria	Effectiveness
Evaluation Question 1	To what extent were the intended project goal, outcomes and outputs achieved and how?
Response to the evaluation question with analysis of key findings by the evaluation team	
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	
Conclusions	
Others	

Evaluation Criteria	Effectiveness
Evaluation Question 2	• To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? • How many beneficiaries have been reached?
Response to the evaluation question with analysis of key findings by the evaluation team	

Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	
Conclusions	
Other	*For this specific question on beneficiaries, please complete the Beneficiary Data Sheet in Annex 4C.

Please repeat the same template per evaluation question.

Instruction for Findings and Analysis

- Findings cover all of the evaluation objectives and the key evaluation questions agreed in the evaluation TOR and during the inception stage (inception report).
- Outputs, outcomes and goal of the project are evaluated to the extent possible (or an appropriate rationale given as to why not).
- Outcomes and goal include any unintended effects, whether beneficial or harmful.
- The report makes a logical distinction in the findings, showing the progression from implementation of the activities to the results (outputs, outcomes and project goal) with an appropriate measurement and analysis of the results chain, or a rationale as to why an analysis of results was not provided.
- Findings regarding inputs for the completion of activities or process achievements are distinguished clearly from the results of the projects (i.e. outputs, outcomes and project goal).
- Results attributed to the success/failure of the project are related back to the contributions of different stakeholders.
- Reasons for accomplishments and difficulties of the project, especially constraining and enabling factors, are identified and analyzed to the extent possible.
- Based on the findings, the evaluation report includes an analysis of the underlying causes, constraints, strengths on which to build on, and opportunities.
- An understanding of which external factors contributed to the success or failure of the project helps determine how such factors will affect the future initiatives, or whether it could be replicated elsewhere.

For evaluation questions related to lessons learned and promising practices

- Lessons and promising practices that contributes to general knowledge in the context of Ending Violence against Women, including innovative and catalytic methodologies/approaches.
- The analysis presents how lessons and promising practices can be applied to different contexts and/or different actors, and takes into account evidential limitations such as generalizing from single point observations.
- They are well supported by the findings and conclusions of the evaluation and are not a repetition of common knowledge.

13. Conclusions

[The template below must be used to provide conclusions organized per evaluation criteria, in addition to those for overall. Evaluators may add additional paragraphs/sub-sections in narrative format if they wish.]

Evaluation Criteria	Conclusions
Overall	
Effectiveness	
Relevance	
Efficiency	
Sustainability	
Impact	
Knowledge Generation	
Others (if any)	

Instruction

- The logic behind the conclusions and the correlation to actual findings are clear.
- Simple conclusions that are already well known are avoided.
- Substantiated by findings consistent with the methodology and the data collected.
- Represent insights into identification and/or solutions of important problems or issues.
- Focus on issues of significance to the project being evaluated, determined by the evaluation objectives and the key evaluation questions.

14. Key recommendations

[The template below must be used to provide recommendations per evaluation criteria. Evaluators may add additional paragraphs/sub-sections in narrative format if they wish.]

Evaluation Criteria	Recommendations	Relevant Stakeholders (Recommendation made to whom)	Suggested timeline (if relevant)
Overall			
Effectiveness			
Relevance			

Efficiency			
Sustainability			
Impact			
Knowledge Generation			
Others (if any)			

Instruction

- Realistic and action-oriented, with clear responsibilities and timeframe for implementation if possible.
- Firmly based on analysis and conclusions.
- Relevant to the purpose and the objectives of the evaluation.
- Formulated in a clear and concise manner.

15. Annexes (mandatory)

The following annexes must be submitted to the UN Trust Fund with the final report.

8) **Final Version of Terms of Reference (TOR) of the evaluation** (in case if the final version has not been submitted yet)

9) **Evaluation Matrix** [see Annex 4A for the template] please provide indicators, data source and data collection methods per evaluation question.

10) **Beneficiary Data Sheet** [see Annex 4C for the template] please provide the total number of beneficiaries reached at the project goal and outcome levels.

11) **Additional methodology-related documentation**, such as data collection instruments including questionnaires, interview guide(s), observation protocols, etc.

12) **Lists of persons and institutions interviewed or consulted and sites visited**
[As appropriate, specification of the names of individuals interviewed should be limited to ensure confidentiality in the report but rather providing the names of institutions or organizations that they represent.]

13) **List of supporting documents reviewed**

14) **CVs of evaluator(s) who conducted the evaluation**

Annex 2: Evaluation matrix

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
Effectiveness	9) To what extent were the intended project goal, outcomes and outputs achieved and how? 10) To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? How many beneficiaries have been reached? 11) To what extent has this project generated positive changes in the lives of targeted (and untargeted) women and girls in relation to the specific forms of violence addressed by this project? Why? What are the key changes in the lives of those women and/or girls? Please describe those changes.	1) Number of sexual assault survivors the trainee has actively examined/interviewed /represented in the 12 months preceding the training; 2) Percent of medical records with key domains documented; 3) Percent of medical records with key medical evidence collected; 4) Experiences of healthcare, law enforcement, and legal sector trainees.	**Data sources**: medical records, semistructured interviews, pre and post training questionnaires **Data collection methods**: *Medical records* Three sites were selected for analysis based on location of the PHR training programs (Kisumu, Nakuru, and Minova). Medical records for all patients visiting each of the three facilities, with a diagnosis of sexual violence from 2009 through 2015 were considered eligible for selection in the medical review (start and end dates for data collection varied by site, but included a total span of 67 months in which the survivor could present to the healthcare facility). Within each facility, sexual violence records were first sorted by year, and sampling intervals were determined within each year to facilitate the systematic random selection of cases from the facility. Thirty six codes were assigned to each medical record (the medical record coding guide is provided in Annex 4 of this report). Measures were focused on medical record quality and medical evidence collected for a single patient. *Semistructured interviews* Semi-structured interviews were conducted with PHR trainees in Kenya and DRC. These trainees included members of the law

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
	12) What internal and external factors contributed to the achievement and/or failure of the intended project goal, outcomes and outputs? How?		enforcement, healthcare, and legal sectors within each country. We conducted 26 semistructured interviews (Kenya 16, DRC 10) with individuals who could provide information pertaining to the core evaluation criteria provided by the UNTF (effectiveness, relevance, sustainability, impact, and knowledge generation). Interviews were audio-recorded and transcribed in the language of the interview (Swahili, English). All manuscripts were translated into English and subject to analysis. *Pre and post training questionnaires* Pre and post training questionnaires were administered by the program relative to training. Questions included background characteristics of the services the respondents provide, including the number of sexual violence cases the trainee has actively examined/interviewed/represented in the 12 months preceding the training.
Relevance	5) To what extent was the project strategy and activities implemented relevant in responding to the needs of women and girls? 6) To what extent do achieved results (project goal,	7) Percent of female survivor medical records with key domains documented; 8) Percent of female survivor medical records with key medical evidence collected; 9) Experiences of healthcare, law	**Data sources**: medical records, semistructured interviews **Data collection methods**: *Medical records* Three sites were selected for analysis based on location of the PHR training programs (Kisumu, Nakuru, and Minova). Medical records for all patients visiting each of the three facilities, with a diagnosis of sexual violence from 2009 through 2015 were considered eligible for

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
	outcomes and outputs) continue to be relevant to the needs of women and girls?	enforcement, and legal sector trainees.	selection in the medical review (start and end dates for data collection varied by site, but included a total span of 67 months in which the survivor could present to the healthcare facility). Within each facility, sexual violence records were first sorted by year, and sampling intervals were determined within each year to facilitate the systematic random selection of cases from the facility. Thirty six codes were assigned to each medical record (the medical record coding guide is provided in Annex 4 of this report). Measures were focused on medical record quality and medical evidence collected for a single patient. *Semistructured interviews* Semi-structured interviews were conducted with PHR trainees in Kenya and DRC. These trainees included members of the law enforcement, healthcare, and legal sectors within each country. We conducted 26 semistructured interviews (Kenya 16, DRC 10) with individuals who could provide information pertaining to the core evaluation criteria provided by the UNTF (effectiveness, relevance, sustainability, impact, and knowledge generation). Interviews were audio-recorded and transcribed in the language of the interview (Swahili, English). All manuscripts were translated into English and subject to analysis.

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
Efficiency	3) How efficiently and timely has this project been implemented and managed in accordance with the Project Document?	1) Target ratio of spending to number of people trained 2) Actual ratio of spending to number of people trained 3) Correlation between billing amounts and number of people trained (bi-annual)	**Data sources:** Program report on 6-month billing and 6-month training completions. **Data collection methods:** Program data requested by email from PHR program, data delivered to evaluation team by email.
Sustainability	3) How are the achieved results, especially the positive changes generated by the project in the lives of women and girls at the project goal level, going to be sustained after this project ends?	1) Forecasted percent of medical records with select domains documented; 4) Forecasted percent of medical records with select medical evidence collected; 5) Experiences of healthcare, law enforcement, and legal sector trainees.	**Data sources**: medical records, semistructured interviews **Data collection methods**: *Medical records* Three sites were selected for analysis based on location of the PHR training programs (Kisumu, Nakuru, and Minova). Medical records for all patients visiting each of the three facilities, with a diagnosis of sexual violence from 2009 through 2015 were considered eligible for selection in the medical review (start and end dates for data collection varied by site, but included a total span of 67 months in which the survivor could present to the healthcare facility). Within each facility, sexual violence records were first sorted by year, and sampling intervals were determined within each year to facilitate the systematic random selection of cases from the facility.

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
			Thirty six codes were assigned to each medical record (the medical record coding guide is provided in Annex 4 of this report). Measures were focused on medical record quality and medical evidence collected for a single patient. *Semistructured interviews* Semi-structured interviews were conducted with PHR trainees in Kenya and DRC. These trainees included members of the law enforcement, healthcare, and legal sectors within each country. We conducted 26 semistructured interviews (Kenya 16, DRC 10) with individuals who could provide information pertaining to the core evaluation criteria provided by the UNTF (effectiveness, relevance, sustainability, impact, and knowledge generation). Interviews were audio-recorded and transcribed in the language of the interview (Swahili, English). All manuscripts were translated into English and subject to analysis.
Impact	3) What are the unintended consequences (positive and negative) resulted from the project?	1) Percent of medical record cases with survivors reporting to a healthcare facility >3 days following the date of the assault, 2) Experiences of healthcare, law enforcement, and legal sector trainees.	**Data sources**: medical records, semistructured interviews **Data collection methods**: *Medical records* Three sites were selected for analysis based on location of the PHR training programs (Kisumu, Nakuru, and Minova). Medical records for all patients visiting each of the three facilities, with a diagnosis of sexual violence from 2009

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
			through 2015 were considered eligible for selection in the medical review (start and end dates for data collection varied by site, but included a total span of 67 months in which the survivor could present to the healthcare facility). Within each facility, sexual violence records were first sorted by year, and sampling intervals were determined within each year to facilitate the systematic random selection of cases from the facility. Thirty six codes were assigned to each medical record (the medical record coding guide is provided in Annex 4 of this report). Measures were focused on medical record quality and medical evidence collected for a single patient. *Semistructured interviews* Semi-structured interviews were conducted with PHR trainees in Kenya and DRC. These trainees included members of the law enforcement, healthcare, and legal sectors within each country. We conducted 26 semistructured interviews (Kenya 16, DRC 10) with individuals who could provide information pertaining to the core evaluation criteria provided by the UNTF (effectiveness, relevance, sustainability, impact, and knowledge generation). Interviews were audio-recorded and transcribed in the language of the interview (Swahili, English). All manuscripts were translated into English and subject to analysis.

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
Knowledge Generation	5) What are the key lessons learned that can be shared with other practitioners on Ending Violence against Women and Girls? 6) Are there any promising practices? If yes, what are they and how can these promising practices be replicated in other projects and/or in other countries that have similar interventions?	1) Experiences of healthcare, law enforcement, and legal sector trainees.	**Data sources**: semistructured interviews **Data collection:** Semi-structured interviews were conducted with PHR trainees in Kenya and DRC. These trainees included members of the law enforcement, healthcare, and legal sectors within each country. We conducted 26 semistructured interviews (Kenya 16, DRC 10) with individuals who could provide information pertaining to the core evaluation criteria provided by the UNTF (effectiveness, relevance, sustainability, impact, and knowledge generation). Interviews were audio-recorded and transcribed in the language of the interview (Swahili, English). All manuscripts were translated into English and subject to analysis.

Annex 3: Beneficiary data sheet

2.3.1 Beneficiary Data Sheet

		The number of beneficiaries reached	
Beneficiary group		**At the project goal level**	**At the outcome level**
Female domestic workers			
Female migrant workers			
Female political activists/human rights defenders			
Female sex workers			
Female refugees/internally displaced/asylum seekers			
Indigenous women/from ethnic groups			
Lesbian, bisexual, transgender			
Women and girls in general			
Women/girls with disabilities			
Women/girls living with HIV and AIDS			
Women/girls survivors of violence		17,448	
Women prisoners			
Others (specify)			
Primary Beneficiary Total		**17,448**	**N/A**
Civil society organizations (including NGOs)	Number of institutions reached	NA	N/A
	Number of individuals reached	NA	78
Community-based groups/members	Number of groups reached	NA	N/A
	Number of individuals reached	NA	35
Educational professionals (i.e. teachers, educators)		NA	14
Faith-based organizations	Number of institutions reached	NA	N/A
	Number of individuals reached	NA	12
General public/community at large		NA	N/A
Government officials (i.e. decision makers, policy implementers)		NA	64
Health professionals		NA	229
Journalists/Media		NA	25
Legal officers (i.e. lawyers, prosecutors, judges)		NA	160
Men and/or boys		NA	1000+
Parliamentarians		NA	101
Private sector employers		NA	25
Social/welfare workers		NA	18
Uniformed personnel (i.e. police, military, peace-keeping officers)		NA	417

Others (specify) (Students, UN officials)	NA	287
Secondary Beneficiary Total	NA	1238 *

*Please note: this number represents unique individuals. Individuals appearing in more than one category are counted each time in the appropriate category but only once in the Total. Also note that this figure includes all individuals with whom the Program has had meaningful contact, in addition to individuals trained.

Annex 4: Methodology-related documentation

MEDICAL RECORD REVIEW CODING GUIDE

First enter the location that the medical record review is being conduct in the top left hand corner of each page. Then, assign a numeric value to each variable name in the "Medical Record Review Entry Form" for each medical record.

Variable number	Variable name	Item	Numeric value
1	PAT	Patient #	*Enter (unique research ID#)*
2	FOR	Is the medical record of sexual assault formatted?	*0=sexual assault medical record is unstructured, not formatted, completely hand written;* *1=sexual assault medical record includes some type of structured form*
3	LEG	Is the writing in the medical record legible?	*0=No;* *1=Yes*
4	GND	Gender of patient	*0=Male;* *1=Female;* *99=Missing*
5	MAR	Marital status of patient	*0=Single;* *1=Married;* *2=Partnered but not married;* *3=Widowed;* *4=Other;* *99=Missing*
6	DAT	Date of examination	*Enter Date (Day/Month/Year)*
7	TIM	Was time of examination documented?	*0=Not documented;* *1=Documented*
8	DOA	Date of assault	*Enter Date (Day/Month/Year);* *99=Missing*
9	TOA	Was time of assault documented?	*0=Not documented;* *1=Documented*
10	NOP	Number of perpetrators	*Enter number of perpetrators; 99=Missing*
11	GOP	Gender of perpetrator	*0=Female; 1=Male;* *99=Missing*
12	APK	Alleged perpetrators Known	*0=No;* *1=Yes;* *99=Missing*
13	APD	Was the age of the perpetrator documented?	*0=Not documented;* *1=Documented*
14	LAD	Was the location of the assault documented?	*0=Not documented;* *1=Documented*

Variable number	Variable name	Item	Numeric value
15	CCD	Was the chief complaint/presenting complaint documented?	*0=Not documented; 1=Documented*
16	TSA	Type of Sexual Assault (enter all that apply)	*1=oral; 2=vaginal; 3=Anal; 4= other Specify; 99=Missing*
17	WCU	Was a condom used?	*0=No; 1=Yes; 99=Missing*
18	WWU	Weapons Used?	*0=No; 1=Yes; 99=Missing*
19	HPR	History of previous Rape ?	*0=No; 1=Yes; 99=Missing*
20	DSC	Documentation of whether the survivor changed clothes?	*0=Not documented; 1=Documented*
21	DPP	Documentation of whether the clothes were placed in a non-plastic paper bag?	*0=Not documented; 1=Documented*
22	DWB	Documentation of whether the survivor bathed?	*0=Not documented; 1=Documented*
23	SNM	Was there evidence of the survivor's narrative description of events in the medical record?	*0=Not documented; 1=Documented*
24	PCP	Was there documented of PCP, ECP, stitching/surgical procedures, and/or STI treatment?	*0=Not documented; 1=Documented*
25	ADP	Were anatomical diagrams present in the medical record (to indicate injuries, inflammation, marks on various body parts of the survivor)?	*0=Not documented; 1=Documented*
26	RTP	Was there documentation of referrals (e.g. to police, legal, HIV testing, trauma counseling, safe shelter)?	*0=Not documented; 1=Documented*
27	AST	Was an anal swab taken?	*0=No; 1=Yes; 99=Missing*
28	SST	Was a skin swab taken?	*0=No; 1=Yes; 99=Missing*
29	OST	Was an oral swab taken?	*0=No; 1=Yes; 99=Missing*
30	OGS	Was an outer genital swab taken?	*0=No; 1=Yes; 99=Missing*
31	HVS	Was a high vaginal swab taken?	*0=No; 1=Yes; 99=Missing*
32	UST	Urine sample taken?	*0=No; 1=Yes; 99=Missing*
33	BST	Blood sample taken?	*0=No; 1=Yes; 99=Missing*
34	PHS	Pubic hair sample taken?	*0=No; 1=Yes; 99=Missing*
35	NCT	Nail clippings taken?	*0=No; 1=Yes; 99=Missing*
36	OFB	Were other foreign bodies collected?	*0=No; 1=Yes; 99=Missing*

RECORD REVIEW ENTRY FORM **LOCATION**_____ **CODER'S NAME**_____ **DATE CODING TOOK PLACE** _____

Var. #	Variable name	1	2	3	4	5	6	7	8	9	10
1	PAT										
2	FOR										
3	LEG										
4	GND										
5	MAR										
6	DAT										
7	TIM										
8	DOA										
9	TOA										
10	NOP										
11	GOP										
12	APK										
13	APD										
14	LAD										
15	CCD										
16	TSA										
17	WCU										
18	WWU										
19	HPR										
20	DSC										
21	DPP										
22	DWB										
23	SNM										
24	PCP										
25	ADP										
26	RTP										
27	AST										
28	SST										
29	OST										
30	OGS										
31	HVS										
32	UST										
33	BST										
34	PHS										
35	NCT										
36	OFB										

Semi-structured interview guide for individuals who have been trained by PHR

Date	|___||___| / |___||___| / |___||___| *(dd/mm/yyyy)*
Primary Interviewer Name	
Country	
Location of interview	
Healthcare, Legal, or Law Enforcement Professional?	
Audio record number	
Translator	

[INTERVIEWER: READ VERBAL CONSENT AND SIGN/DATE CONSENT STATEMENT BEFORE PROCEEDING]

A. BACKGROUND

1. What is your professional position?

2. How long have you been working with this organization/agency/unit?

3. Approximately how many people work here?

4. How many people here are tasked to work with cases of sexual violence?

Now I am going to ask you some questions about your professional practices and your attitudes relative to the training conducted by Physicians for Human Rights. Remember, there are no wrong answers. This interview is only to help us better identify things that we can do to better improve our training and technical assistance efforts.

INTERVIEWERS – GO TO SECTION:

B *FOR HEALTHCARE PROFESSIONALS (PAGE 3)*

C *FOR LAW ENFORCEMENT PROFESSIONALS (PAGE 5)*

D *FOR LEGAL PROFESSIONALS (PAGE 7)*

B. QUESTIONS FOR HEALTHCARE PROFESSIONALS ONLY

1. How many people from your health unit were trained at the Training with Physicians for Human Rights?

2. Can you estimate about how many women and/or girls you have screened for sexual violence since the training with Physicians for Human Rights?

3. Do you feel that the Training with Physicians for Human Rights was relevant in responding to the needs of women and girls?
   probe→How so?

4. Did you change anything about your professional practices following the training with Physicians for Human Rights?
   Probe→ how you collect forensic evidence of sexual assault?
   Probe→ how you provide medical care to survivors of sexual assault?
   Probe→ how you refer survivors to other healthcare professionals and/or other sectors?

5. Have you altered or developed any forms for medical evaluation, particularly regarding forms documenting sexual violence, since the Training with Physicians for Human Rights? Please describe any alterations or new forms.

6. During the Training with Physicians for Human Rights, forensic backpacks were distributed. Have you found the materials in the backpack to be helpful? Do you still use the materials in the backpack?

7. Do you feel that your personal response to survivors of sexual violence has changed since the Training with Physicians for Human Rights?
   [if yes, probe]→ How soon after the training did your response change? Do you feel that your response has resulted in better case outcomes for survivors of sexual violence?

8. Since the Training with Physicians for Human Rights, has your opinion regarding the documentation of sexual violence changed in any way?

9. Has your relationship with the police changed since the Training with Physicians for Human Rights?

10. Have you found it easier or more difficult to communicate with the police regarding sexual violence cases?

11. How do you personally feel about making an effort to document evidence surrounding sexual violence?

12. Did anything about the Training with Physicians for Human Rights make you feel more or less secure regarding your role in documenting evidence of sexual violence?

13. Did you forge any new professional relationships with police officers as a result of the Training with Physicians for Human Rights?

14. Did you forge any new professional relationships with lawyers or judges as a result of the Training with Physicians for Human Rights?

15. Has clinical data that you have collected ever been used to prosecute a perpetrator of sexual violence in court?
[if yes, probe] → how many perpetrators?
→ when [before or after PHR training]?
→ how?
→ what was the outcome?

16. Have you ever testified on a sexual violence case in court?
[if yes, probe] → how many times?
→ when [before or after PHR training]?
→ how?
→ what was the outcome?

17. Do you feel that the Training with Physicians for Human Rights prepared you to better document forensic evidence regarding cases of sexual violence?
[if yes, probe] → how so?

18. Do you feel that forensic evidence of sexual assault is treated any differently in your country after the training with Physicians for Human rights?

19. Do you feel that the training with Physicians for Human Rights has generated positive changes in the lives of survivors of sexual violence? What are the key changes in the lives of those women and/or girls?

20. Can you provide one example of a survivor of sexual assault whose experiences were different as a result of Physicians for Human Rights?

21. Do you feel that the Training with Physicians for Human Rights had any unintended consequences? Please describe any positive or negative unintended consequences.

22. Are there any lessons you would share with other practitioners on ending violence against women and girls?

C. QUESTIONS FOR LAW ENFORCEMENT PROFESSIONALS

1. How many law enforcement professionals at your unit attended the Training with Physicians for Human Rights?

2. Can you estimate about how many sexual violence cases you have investigated since the training with Physicians for Human Rights?

3. Can you estimate about how many sexual violence cases your unit has investigated since the training with Physicians for Human Rights?

4. Did you change anything about your professional practices following the training with Physicians for Human Rights?
   Probe→ how you collect forensic evidence of sexual assault?
   Probe→ how you interact with survivors of sexual assault?
   Probe→ how you refer survivors to healthcare professionals and/or professionals in other sectors?

5. Did you transfer any skills from the training to any of your colleagues?
   [if yes, probe] → what skills and how did you decide to train your colleagues? How soon after the training did you transfer these skills?

6. Do you feel that the Training with Physicians for Human Rights was relevant in responding to the needs of women and girls?

7. Do you feel that your response to survivors of sexual violence has changed since the Training with Physicians for Human Rights? [if yes, probe]→ How soon after the training did your response change? Do you feel that your response has resulted in better case outcomes for survivors of sexual violence?

8. Has your system of investigating a sexual violence case changed in any way since the
Training with Physicians for Human Rights? [if yes, probe]→ How soon after the training did your system change? Do you feel that this system has resulted in better case outcomes for survivors of sexual violence?9. Did anything about the Training with Physicians for Human Rights make you feel more or less secure regarding your role in documenting evidence of sexual violence?

10. Has your relationship with physicians changed in any way since the training with Physicians for Human Rights?

11. Has your relationship with lawyers or the legal sector changed in any way since the training with Physicians for Human Rights?

12. Since the Training with Physicians for Human Rights, has your opinion regarding the documentation of sexual violence changed in any way?

13. Has evidence that you have collected ever been used to prosecute a perpetrator of sexual violence in court?
   [if yes, probe] → how many perpetrators?
   → when [before or after training]?
   → how?

→ what was the outcome?

14. Have you ever testified on a sexual violence case in court?
[if yes, probe] → how many times
→ when [before or after training]?
→ how?
→ what was the outcome?

15. Do you feel that the Training with Physicians for Human Rights prepared you to better document forensic evidence regarding cases of sexual violence?
[if yes, probe] → how so?

16. Do you feel that forensic evidence of sexual assault is treated any differently in your country after the training with Physicians for Human Rights?

17. Do you feel that the training with Physicians for Human Rights has generated positive changes in the lives of survivors of sexual violence? What are the key changes in the lives of those women and/or girls?

18. Can you provide one example of a survivor of sexual assault whose experiences were different as a result of Physicians for Human Rights?

19. Do you feel that the Training with Physicians for Human Rights had any unintended consequences? Please describe any positive or negative unintended consequences.

20. Are there any lessons you would share with other practitioners on ending violence against women and girls?

21. What do you feel needs to happen in your country for individuals in the field of law enforcement to be able to better document cases of sexual violence?

D. QUESTIONS FOR LEGAL PROFESSIONALS

1. How many legal professionals from your court/unit/office attended training?

2. Did you transfer any skills from the training to any of your colleagues? [if yes, probe] → what skills and how did you decide to train your colleagues? How soon after training did you transfer any skills?

3. Do you feel that the Training with Physicians for Human Rights was relevant in responding to the needs of women and girls?

4. Has your use of medical evidence changed since the Training with Physicians for Human Rights? [if yes, probe]→ How soon after the training did your use of medical evidence change? Do you feel that your use of medical evidence has resulted in better case outcomes for survivors of sexual violence?

5. Has your professional relationship with the law enforcement system regarding sexual violence cases changed in any way since the training with Physicians for Human Rights?

6. Have police records changed in any way since the training with Physicians for Human Rights?

7. Has your use of police records changed since the Training with Physicians for Human Rights? [if yes, probe]→ How soon after the training did your use of police records change? Do you feel that your use of police records has resulted in better case outcomes for survivors of sexual violence?

8. Did you meet anyone at the Training with Physicians for Human Rights who has since helped you better utilize evidence in a sexual violence case?

9. Can you estimate about how many sexual violence cases you have worked on since the training with Physicians for Human Rights?

10. Can you estimate about how many sexual violence cases your unit/court has worked on since the training with Physicians for Human Rights?

11. How many cases of sexual violence resulted in a conviction during the past year? Do you think the conviction rate has changed since the training? How?

12. Has the testimony of professional witnesses (specifically, healthcare professionals or law enforcement officers) changed in any way since the training with Physicians for Human Rights?

13. Have you found it easier or more difficult to communicate with the police regarding sexual violence cases since the training with Physicians for Human Rights?

14. Did anything about the Training with Physicians for Human Rights make you feel more or less secure regarding your role in handling evidence of sexual violence?

15. Since the Training with Physicians for Human Rights, has your opinion regarding the documentation of sexual violence changed in any way?

16. Do you feel that the training with Physicians for Human Rights has generated positive changes in the lives of survivors of sexual violence? What are the key changes in the lives of those women and/or girls?

17. Can you provide one example of a survivor of sexual assault whose experiences were different as a result of Physicians for Human Rights?

18. Do you feel that the Training with Physicians for Human Rights had any unintended consequences? Please describe any positive or negative unintended consequences.

19. Are there any lessons you would share with other practitioners on ending violence against women and girls?

E. WRAP-UP

1. Have there been any other changes that you have experienced in your professional experience since the training you attended with Physicians for Human Rights?

2. Have there been any new professional relationships with individuals that you have forged since the Training with Physicians for Human Rights?

3. In retrospect, what have been some of the most helpful aspects of the training that PHR provided?

VERBAL CONSENT FORM FOR PROFESSIONALS TRAINED BY PHR

ORGANIZATION CONDUCTING INTERVIEW: I am working with RTI International and Physicians for Human Rights, two organizations based in the United States of America. _____ (Initials)

DESCRIPTION OF INTERVIEW: I am conducting an interview with you because you or someone from your organization participated in a training conducted by, or received technical assistance from Physicians for Human Rights. This interview will be recorded on a tape recorder and your name will not be associated with the tape. I will record this interview onto a computer chip and transport this chip back to the United States where the words of our conversation will be typed onto a separate piece of paper, and your name will not be on that paper either. This tape will then be destroyed. Your name or identification information will not be linked back to this interview. The interview transcript, devoid of identifiers, will be available to the study team on password-protected computers. I might take notes as you talk _____ (Initials).

RISKS AND BENEFITS OF THE INTERVIEW: We hope to use this Interview to find out more information about your professional experiences. There are no direct risks associated with participating in this interview. However, if you do not wish to answer a question, you can skip the question. We do not want you to give us your name at all. If you do give us your name or other personally identifiable information, we will remove or change that information in the transcript produced from this interview. This interview is voluntary and you are free to stop at any time during the interview. _____ (Initials)

TIME INVOLVEMENT: Your participation in this interview will take approximately 30 minutes to one hour. _____ (Initials)

COMPENSATION: There is no payment or compensation for your participation in this interview. _____ (Initials)

YOUR RIGHTS: I have read this form to you and you have decided to participate in this project. Please understand that your participation is voluntary and you have the right to withdraw your consent or discontinue participation at any time without penalty or loss of benefits to that you are otherwise entitled. You have the right to refuse to answer particular questions. Your identity will not be disclosed at all. Your individual privacy will be maintained in all published and written data resulting from the study. A copy of this consent form will be left with you. _____ (Initials)

CONTACTS: If you have questions about your rights as a research participant, you can contact Michael Anastario at RTI International (email: manastario@rti.org).

I confirm that this information has been reviewed with the research participant, who has had a chance to ask questions and agrees to take part in this interview.

_____

Signature of Representative Date

Axial Codes for Interviews Conducted in Kenya

Flag	Axial code	Axial code description
Effectiveness	**E-PRAC**	PHR training affecting daily practices or knowledge
	E-NETW	PHR training improving networking
	E-SURV	PHR training improving survivor interactions
	E-NG	PHR training have no effect or negative effect on practices
	E-BASE	respondent describing practices before training
Relevance	**R-SURV**	respondents addressing needs of women and girls
	R-OUT	respondents describing outcomes for women and girls
	R-REACH	respondents describing number of cases seen since training
Efficiency	**C-Conf**	respondent describing confidence in skills and abilities
	C-Comm	respondents communicating with other sectors
	C-Sys	respondent explaining system changes or lack thereof
Sustainability	**S-COL**	collaborating with other sectors
	S-FE	changing forensic evidence views and practices
	S-SET	respondent experiencing setbacks
	S-TEACH	respondent training or teaching others
	S-RESP	changing response to survivors or cases of sexual violence
Impact	**I-UN**	respondent reporting unintended consequence (positive or negative)
	I-COURT	respondent describing testifying and providing evidence for court cases
	I-OUT	describing case outcomes
Knowledge Generation	**K-TRAIN**	respondents describing best parts of training
	K-REC	respondents providing recommendations or lessons
	K-UM	respondents describing unmet needs

Axial Codes for Interviews Conducted in the Democratic Republic of Congo

Flag	Axial code	Axial code description
Effectiveness	**E-PRAC**	PHR training affecting daily practices or knowledge
	E-NETW	PHR training improving networking
	E-SURV	PHR training improving survivor interactions
	E-NG	PHR training have no effect or negative effect on practices
	E-BASE	respondent describing practices before training
Relevance	**R-SURV**	respondents addressing needs of women and girls
	R-OUT	respondents describing outcomes for women and girls
	R-REACH	respondents describing number of cases seen since training
Efficiency	**C-Conf**	respondent describing confidence in skills and abilities
	C-Comm	respondents communicating with other sectors
	C-Sys	respondent explaining system changes or lack thereof
	C-Vio	respondents fearing violent retribution
Sustainability	**S-COL**	collaborating with other sectors
	S-FE	changing forensic evidence views and practices
	S-SET	respondent experiencing setbacks
	S-TEACH	respondent training or teaching others
	S-RESP	changing response to survivors or cases of sexual violence
Impact	**I-UN**	respondent reporting unintended consequence (positive or negative)
	I-COURT	respondent describing testifying and providing evidence for court cases
	I-OUT	describing case outcomes
Knowledge Generation	**K-TRAIN**	respondents describing best parts of training
	K-REC	respondents providing recommendations or lessons
	K-UM	respondents describing unmet needs

Annex 5: Lists of institutions interviewed or consulted and sites visited

1. Institutions and sites visited

	PROFESSIONAL HEALTHCARE	Activity
	- Kenyatta National Hospital, Nairobi	Semistructured interviews
	- German Doctors, Nairobi	Semistructured interviews
	- Mama Lucy Kibaki Hospital - Nairobi	Semistructured interviews
	- Neema Hospital, Nairobi	Semistructured interviews
	- Jaramogi Oginga Odinga Teaching and Referral Hospital	Semistructured interviews
	- Naivasha District Hospital	Semistructured interviews
	- Rift Valley Provincial General Hospital	Record reviews
	- Jaramogi Oginga Odinga Teaching and Referral Hospital	Record reviews
	– Hopital general de refrence de Minova	Record reviews
	JUDICIARY/LEGAL PROFESSIONAL	
	- Prosecutor (Kibera Law Courts), Nairobi	Semistructured interviews
	- Senior Resident Magistrate, Kisumu	Semistructured interviews
	- Bukavu Military Magistrate	Semistructured interviews
	- Clinique Jurisdique	Semistructured interviews
	LAW ENFORCEMENT	
	- Muthaiga Police Station, Nairobi	Semistructured interviews
	- Nakuru Police Station	Semistructured interviews
	- Bukavu Military Police	Semistructured interviews

Summary

Site	Health care	Legal	Law Enforcement
Kenya			
Nairobi	8	1	1
Kisumu	1	1	-
Nakuru/Naivasha	3	-	1
DRC			
Bukavu	3	2	1
Goma	3	-	-
Minova	1	-	-

Annex 6: List of supporting documents reviewed

1. List of supporting documents reviewed

- 400 patient medical records from Rift Valley Provincial General Hospital in Nakuru, Kenya
- 400 patient medical records from Jaramogi Oginga Odinga Teaching and Referral Hospital in Kisumu, Kenya
- 336 patient medical records from Hopital general de reference in Minova, DRC
- 16 semistructured interview transcripts collected in Kenya
- 10 semistructured interviews transcripts collected in DRC

Annex 7: CVs of evaluators who conducted the evaluation