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Deepening and Expanding the Cross-Sector Network Response to Sexual Violence in the DRC and Kenya: A Project to Increase Justice for Women and Girls Survivors of Sexual Violence

Evaluation Report
Kenya and DRC

January 2016 – December 2018

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This Final Evaluation has been developed by an independent evaluator. The analysis presented in this report reflects the views of the author and may not necessarily represent those of the commissioning organization Physician for Human Rights, its partners, or the UN Trust Fund.

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Acronyms and abbreviations

PHR	Physicians for Human Rights
UNTF	United Nations Trust Fund to End Violence against Women
DRC	Democratic Republic of the Congo
SGBV	Sexual and gender-based violence
TOR	Terms of Reference
EVAW/G	Ending violence against women/girls
UNEG	United Nations Evaluation Group
PRC	Post-Rape Care
UNDP	United Nations Development Program
US	United States
APT	Advance pediatrics training
CME	Continuing medical education
HIV	Human Immunodeficiency Virus
MONUSCO	The United Nations Organization Stabilization Mission in the Democratic Republic of the Congo
FARDC	The Armed Forces of the Democratic Republic of the Congo
DNA	Deoxyribonucleic acid
MSF	Médecins Sans Frontières
NGO	Non-governmental organization
ToT	Training of Trainers
CAR	Central African Republic
NGEC	National Gender and Equality Commission
CUC	Court Users' Committee
NCAJ	National Committee on the Administration of Justice
PEP	Post-exposure prophylaxis
VDRL	Venereal Disease Research Laboratory test
RR	Respiratory Rate
ECP	Emergency contraceptive pill

Tables and figures

Executive summary

Context and project being evaluated

Professionals in systems that provide services to survivors of sexual violence in Central and East Africa often lack access to resources, training, and systems that provide comprehensive 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. Building upon prior experience, this current project (2016-2018) includes advanced training, advocacy, institutional capacity development, and sustainable systemic support. 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 are to (1) evaluate the entire project in terms of effectiveness, relevance, efficiency, sustainability, impact, gender equality and human rights, with a strong focus on assessing the results in the occupational practices of secondary beneficiaries and services provided directly to primary beneficiaries; (2) generate key lessons and identify promising practices for implementation; and (3) inform the greater practitioner and research communities about the impact of PHR's project.

Intended audience

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

Methodology

We used a mixed-methods evaluation strategy to complete this impact assessment. We reviewed legal and medical record in control and interventions sites in Kibera and Nakuru, Kenya over a 37-month period (24 months prior to the intervention, 1 month during, 12 months post). We examined a core set of variables concerning legal and medical record documentation and thoroughness measures relative to the date of PHR program exposure in a selected intervention jurisdiction (October 2017 in Nakuru, Kenya). Data were collapsed by month and subject to multiple-group interrupted time series analysis. The qualitative component included 87 semistructured interviews (Kenya 57, DRC 30) with individuals who could provide information pertaining to the core evaluation criteria provided by the UNTF. An inductive approach was adopted to code and analyze data for themes. Prospectively monitored program tracking outputs and outcomes were also collected and analyzed to report on various programmatic activities over the course of the project, including: the training of colleagues; the development of Memorandums of Understanding with institutions; patient pathway and service assessments completed at health centers; the status of recommendation documents provided to health centers; the status of institutional plans that detail how institutions will integrate forensic training material into curriculums, protocols, practices, and

in-service and pre-service trainings by project end; the status of agreements between PHR and selected institution; and the new research projects implemented by the program.

Findings and conclusions

There is evidence to suggest that the program was able to achieve key changes in support of its goal to deepen and expand cross-sector responses to sexual violence in ways that improve medical and psychological documentation of sexual assault, strengthen police investigations, and to increase the likelihood of justice and reparations for women and girl survivors of sexual violence. It is particularly notable that perceptions of and quantitative evidence of adjudication outcomes favoring the survivor increased in the period immediately following the intervention, and that the relative amount of medical evidence in the Post-Rape Care form appearing in the legal record (a key focus of PHR's programming) was associated with an increased likelihood of an adjudication outcome favoring the survivor. The evidence used to examine this impact was based on extensive qualitative interviews with secondary beneficiaries including individuals from the healthcare, legal, and law enforcement sectors, systematic medical and legal record reviews, and a review of existing program monitoring data.

Recommendations

We recommend that the PHR program publish key findings derived from the medical and legal record reviews in the peer reviewed literature. Further, we recommend that PHR and UNTF make core training materials available to medical and nursing school faculty responsible for forensic training in Kenya and the DRC.

1. Project context and background

1.1 Context of the project

This impact analysis concerns the evaluation of a three-year program executed by Physicians for Human Rights (PHR) with funding from the United Nations Trust Fund to End Violence against Women (UNTF).

With funding from the UNTF, PHR's programmatic goal was to deepen and expand cross-sector responses to sexual violence in ways that improve medical and psychological documentation of sexual assault, strengthen police investigations, and to increase the likelihood of justice and reparations for women and girl survivors of sexual violence. Programmatic activities pertinent to this impact analysis were conducted in Kenya and the Democratic Republic of the Congo (DRC) from 2015 to 2018. During that three-year period, PHR worked with key stakeholders; built relationships with leading hospitals, police, military, and government officials, and international and local NGOs; created and expanded training curriculum to respond to local conditions and cover a growing number of topics; developed and piloted MediCapt, a digital tool to enhance evidence collection; and trained professionals in the use of forensic techniques to document sexual violence.

This project is based on the premise that visible, successful prosecutions and convictions as well as provision of judicial remedies such as court-imposed reparations for survivors 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 for Sexual Violence in Conflict; numerous government leaders including former US Secretary of State Hillary Rodham Clinton; and by PHR's local colleagues in countries where sexual violence is widespread and systematic.

By working in this region in this manner, PHR aimed to increase accessibility to justice among survivors of sexual violence in Kenya and the DRC. The program defined increased access to justice as *improvements in the receipt of quality medical and psychological care; medical documentation; adequate investigations; successful prosecutions; evidence-based findings in court, and reparations*. As such, the framework that was used to design this impact analysis accounted for the fact that changes in services and the providers delivering those services would affect sexual violence survivors' ability to access justice.

1.2 Description of the project

1.2.1 Duration and location

Duration:

The project, "Deepening and Expanding the Cross-Sector Network Response to Sexual Violence in the DRC and Kenya: A Project to Increase Justice for Women and Girls Survivors of Sexual Violence" was implemented by PHR for a 3-year period beginning on January 1, 2016 and ending on December 31, 2018.

Location:
The program currently works in the DRC and Kenya. In particular, the program works in Kenya (the Rift Valley Region and Eldoret, Kisumu, and Nairobi) and the Eastern DRC (South Kivu and North Kivu).

1.2.2 Forms of violence addressed
The project specifically addressed violence in the family (intimate partner violence, sexual violence, non-partner violence), violence in the community (sexual violence by non-partners (rape/sexual assault)), and violence perpetrated or condoned by the state (gender-based violence during armed conflict).

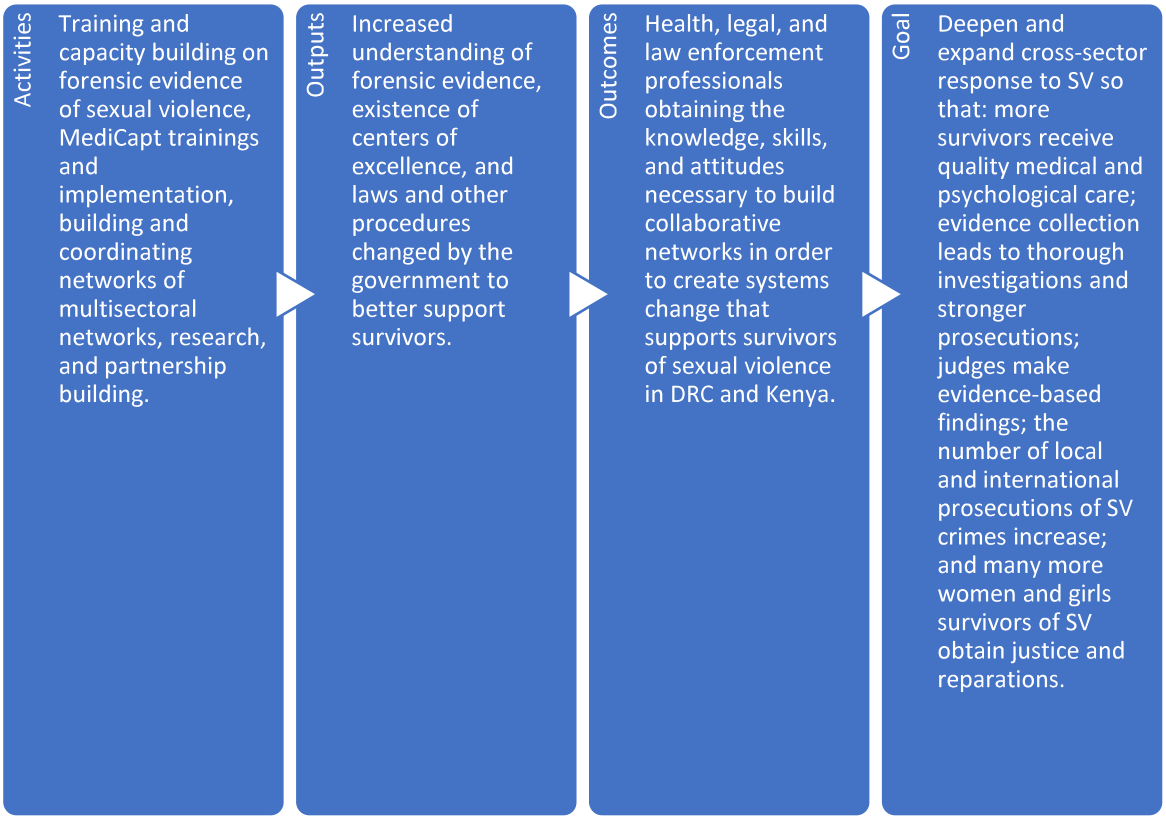
1.2.3 Main objectives
The main objectives of the project were to promote best practices and deepen impact by broadening PHR's ongoing program on Sexual Violence in Conflict Zones, which has demonstrated the value of training professionals across medical, legal, and police sectors to collect, analyze, and preserve evidence; integrating forensics into the curriculums of educational institutions; and expanding to new locations where the need is great and PHR's expertise is sought.

1.2.4 Theory of change (results chain)
The project's theory of change posited that: IF there is effective training of local medical, legal, and law enforcement professionals, AND they can master forensic documentation, analysis, and preservation techniques, AND they can support one another to train and mentor additional colleagues, AND they promote best practices in university legal and medical schools, hospital procedures, government agencies, and police academy studies; THEN more clinicians, lawyers, judges and police investigators will understand the role of forensic evidence in the pursuit of justice; AND prosecutions for crimes of sexual violence will be more effective because they are evidence based; AND forensic training will be embedded in government ministries with investigative, justice, and health mandates, university medical and law schools, and police academy; WHICH WILL IN TURN deepen and expand cross-sector response to sexual violence in ways that sustainably improve medical and psychological interventions, law enforcement investigations, and the likelihood of justice and reparations for women and girl survivors of sexual violence. BECAUSE Forensic evidence properly collected, analyzed, and preserved creates a record of events that is difficult to dispute in justice settings; AND such documentation, rooted in science and medicine and resistant to revisionism, will support increased local and international prosecutions of sexual violence crimes and the aspiration that accountability can supplant impunity – contributing broadly to more stable, secure, and just societies.

The strategy proposed by PHR was to employ proven training strategies to deepen the skills of people who are already part of the regions' 13 training networks – including preparing select members to become mentors and trainers; expanding the cross-sector approach to ending impunity to new regions and countries; integrating forensic training in universities and hospitals to create "centers of excellence"; cultivating local and national governmental relationships that can promote the value of forensics and evidence-based prosecutions; conducting research to better understand the obstacles to justice for women and girl survivors of sexual violence, to support advocacy, and to confirm best practices to support expansion and replication.

The results chain included specification of project activities, outputs, outcomes, and a project goal. The results chain is illustrated in Figure B below.

Figure A. PHR program results chain



The PHR program engages in activities that include training and capacity building. These program activities lead to outputs that include knowledge acquisition and institutional changes. Program outcomes are focused on professionals obtaining the knowledge, skills, and attitudes necessary to build collaborative networks. These changes are aimed at the overall goal of survivors receiving improved services that make justice more accessible (goal).

1.2.5 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 located within supportive institutions and systems will gather better evidence that will be used to prosecute perpetrators of sexual violence and in turn reduce the incidence of sexual violence. Finally, it is presumed that multisectoral collaboration is key, not only for processing cases of sexual violence, but for advocating for and establishing systemic reform.

1.2.6 Targeted beneficiaries, key implementing partners and stakeholders
Primary and secondary beneficiaries:
The primary beneficiaries of the current project include women/girl survivors of violence (15,000); secondary beneficiaries include government officials (50), health professionals (400), legal officers (50), and uniformed personnel (50). Beneficiaries are represented graphically below in Figures A1 and A2 below.

Figure B1. Primary and secondary beneficiaries of PHR's program

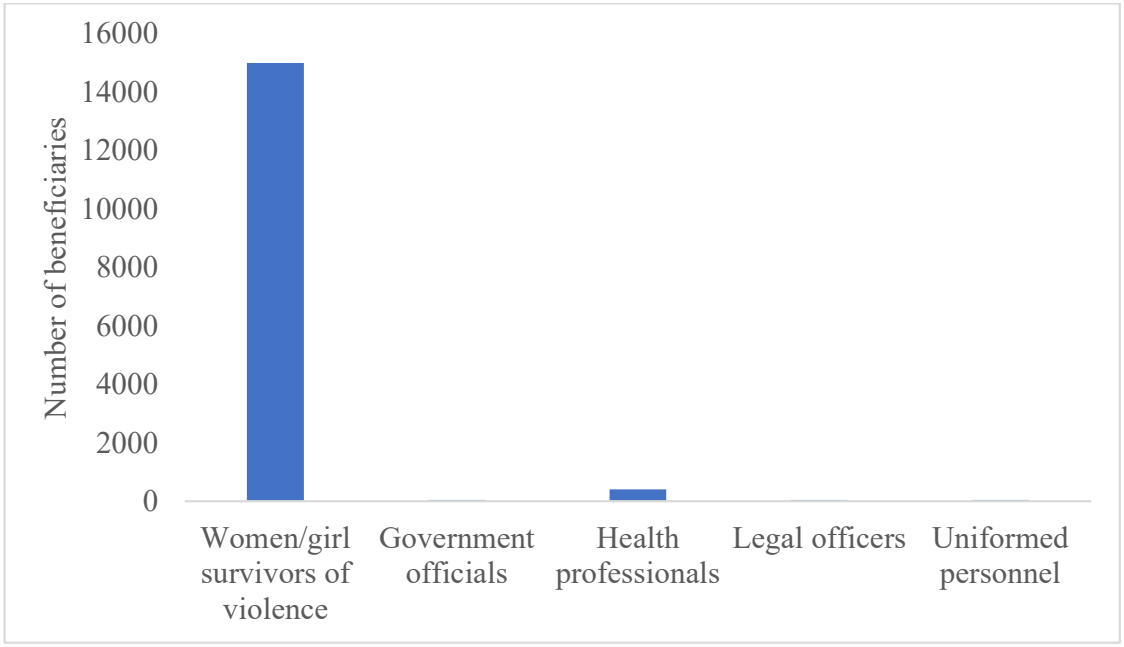
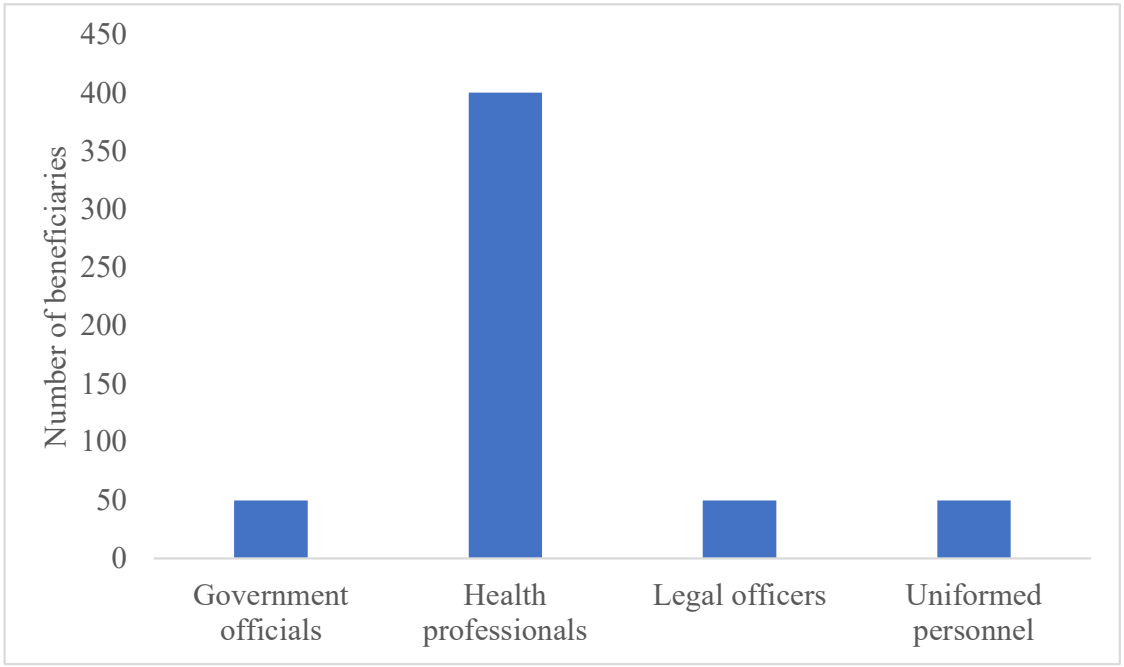


Figure B2. Secondary beneficiaries of PHR's program



Implementing partners and stakeholders:
Key project partners included medical, legal, and law enforcement professionals, Dr. Denis Mukwege of Panzi Hospital (the 2018 Nobel Peace Prize winner), and other key international experts on sexual violence and forensic evidence, government and health officials in Kenya and DRC, and other implementing organizations in the area. PHR also worked to share its in-country experiences in a variety of international arenas, including the Assembly of State Parties at the International Criminal Court, major international conferences, the World Bank, the U.S. Department of State, and others. The program works with many partners. While the following list of partners by country is not comprehensive, it includes a list of key partners.

Key stakeholders and partners include:

DRC

Panzi Hospital, Bukavu General Hospital, Minova, General Hospital, Uvira General Hospital, HEAL Africa, Avocats Sans Frontieres, American Bar Association- ROLI, GBV Unit of Bukavu, UNDP- DRC, UNFPA-DRC, MONUSCO, TRIAL International

Kenya

Kenya National Hospital (Gender-based Violence Recovery Centre), Nairobi Women's Hospital, Mama Lucy Kibaki Hospital, Moi Teaching and Referral Hospital (Eldoret), Nakuru Provincial General Hospital, Naivasha District Hospital, Rift Valley Provincial General Hospital, Naivasha Sub County Referral Hospital, Nakuru Law Courts, Office of Director of Public Prosecutions, Jaramogi Oginga Odinga Teaching and Referral Hospital, the Government Chemist, Kisumu Law Courts, Legal Aid Centre Eldoret (LACE), Kenya Police Service, COVAW, ICJ-Kenya, Wangu Kanja Foundation, Nobel Women's Initiative, ICTJ-Kenya, Institute for Historical Justice and Reconciliation, Columbia University School of International Public Affairs, and the Brandeis University Institute for International Judges.

Other

UNDP-CAR, and the Special Representative of the Secretary-General on Sexual Violence in Conflict.

1.2.7 Project budget and expenditure
The total resources allocated to the intervention by the UNTF, including human resources and budgets, was US$975,000. The program billed for $217,536 in year 1, $348,415 in year 2, and $409,049 in year 3. Over the 3 years of implementation, PHR expended US$975,000.

2. Evaluation background and methodology

2.1 Evaluation purpose, context, scope, objectives, use, and team

2.1.1 Necessity of the evaluation
This current evaluation reflects the mandatory final project evaluation required by the UN Trust Fund to End Violence against Women. With this end in mind, the program commissioned ongoing monitoring and evaluation during the course of the program, with an additional post-program evaluation.

This evaluation is structured to evaluate the overall impact of the PHR program at the level of survivors of sexual assault. As such, medical and legal record reviews were conducted to evaluate survivor-level outcomes concerning the completeness of documentation in survivor records, adjudication outcomes concerning survivor cases, and overall thoroughness of medical forensic documentation for survivor cases. To triangulate findings concerning the linkages between sectors that have been built in support of survivors of sexual assault, semi-structured qualitative interview data with personnel in the medical, law enforcement, and legal sectors was also collected over the course of the program and was accordingly analysed for this impact evaluation.

2.1.2 Context of evaluation

All evaluation activities for this impact assessment received ethics review and oversight from the Georgetown University Institutional Review Board, and local approvals from the hospitals and courts, as well as Nairobi County. An external evaluation team 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. Detailed methodology of the evaluation is provided in following sections.

2.1.3 Scope of evaluation

Timeframe:

This evaluation covered PHR project activities from January 1, 2016 to December 31, 2018. Legal and medical records were retrospectively evaluated to evaluate pre-intervention (two years prior to PHR intervention in a jurisdiction/locale) and post-exposure project periods. We chose the record review methodology instead of directly interviewing survivors so as to not re-traumatize survivors during the program's evaluation.

Geographical Coverage:

This evaluation covered PHR project activities that took place in the Eastern Democratic Republic of the Congo and in the Rift Valley Region of Kenya. However, the record reviews that took place focused on Kenya, as access to records is more reliable, valid, and logistically feasible in Kenya. A target sampling strategy (described in detail in later sections) was used to select intervention and control sites, and systematic random sampling of records was used to select records for review. A purposive sampling strategy was used to select qualitative key informants for participation throughout the project period.

Target groups:

This evaluation triangulated survivor-level impact through three major units of analysis: 1. The legal records of survivors of sexual assault; 2. The medical records of survivors of sexual assault; and 3. Provider/trainee perceptions of changes in the collection and processing of sexual assault evidence across sectors. The previous qualitative findings that particularly focused on the knowledge and practices of PHR program trainees were also used in the final report.

2.1.4 Objectives of the evaluation

The overall objectives of the evaluation are:

a. 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 goals;

b. To generate key lessons and identify promising practices to inform future implementation;

c. To inform the greater practitioner and research communities about the impact of PHR's project.

2.1.5 Use of evaluation results

The evaluation will inform decisions regarding how the program will focus 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; and/or considering other approaches.

The PHR 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 may also be published in a peer-reviewed journal in order to further inform other stakeholders of the results of the evaluation. The findings of this evaluation will be shared and discussed with program staff, partners, participants, and other relevant stakeholders to understand how to improve PHR's work.

2.1.6 Evaluation team and timeline

Evaluation team:

The Evaluation Team consists of an independent evaluator who was assisted by local research data collectors in Kenya.

The lead evaluator, Dr. Michael Anastario, 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. Dr. Anastario is a Sociologist who received his doctoral degree in Sociology from Boston College in 2007. His research generally focuses on sexual violence, mental and reproductive health. He has 14 years of research experience and over 40 research publications. He is currently a 2018-2019 U.S. Fulbright Scholar grantee in International Health, and is a professor of psychology at the Central American University in San Salvador. Dr. Anastario is currently a co-investigator on a R01 grant from the United States National Institute on Minority Health and Health Disparities. He has participated in research activities in Kenya, South Sudan, the DRC, Greenland, El Salvador, and with indigenous tribal communities in the United States. His active research includes ethics oversight from international, tribal, and university-based ethics review committees.

Dr. Anastario worked with local research data collectors in Kenya to collect archival data for this impact analysis. During the course of data collection, he was assisted by Dr. Billy Ulibarri, a Sociologist at the University of Texas Rio Grande Valley, who also conducted semistructured interviews with secondary beneficiaries.

Evaluation timeline:

Table 1. Work plan and timeline of evaluation

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	6	12/09/2018-17/09/2018
	Compiling key documents and existing data		1	18/09/2018
	Recruitment of external evaluator(s)		1	26/09/2018
Inception stage	Briefings of evaluators to orient the evaluators	Evaluation Task Manager	1	01/10/2018
	Desk review of key documents	Evaluation Team	1	02/10/2018 – 03/10/2018
	Finalizing the evaluation design and methods	Evaluation Team	1	03/10/2018
	Preparing an **inception report**	Evaluation Team	1	04/10/2018 – 08/10/2018
	Review Inception Report and provide feedback	Evaluation Task Manager, Reference Group and Advisory Group	1	08/10/2018 – 10/10/2018
	Submitting final version of **inception report**	Evaluation Team	1	15/10/2018
Data collection and analysis stage	Desk research	Evaluation Team	15	1/10/2018-15/02/2019
	In-country technical mission for data collection (visits to the field,	Evaluation Team	30	01/01/2019-01/02/2019

	interviews, questionnaires, etc.)			
Synthesis and reporting stage	Analysis and interpretation of findings	Evaluation Team	16	25/01/2019-11/02/2019
	Preparing a **draft report**	Evaluation Team	20	25/01/2019-15/02/2019
	Review of the draft report with key stakeholders for quality assurance	Evaluation Task Manager, Reference Group, Commissioning Organization Senior Management, and Advisory Group	5	15/02/2019-20/02/2019
	Consolidate comments from all the groups and submit the consolidated comments to evaluation team	Evaluation Task Manger	1	20/02/2019
	Incorporating comments and revising the evaluation report	Evaluation Team	7	20/02/2019-25/02/2019
	Submission of the **final report**	Evaluation Team	1	25/02/2019
	Final review and approval of report	Evaluation Task Manager, Reference Group, Commissioning Organization Senior Management, and Advisory Group	2	26/02/2019
Dissemination and follow-up	Publishing and distributing the final report	Commissioning Organization led by Evaluation Task Manager	3	27/02/2019 – 10/03/2019

	Prepare management responses to the key recommendations of the report	Senior Management of Commissioning Organization	2	10/03/2019 – 15/03/2019
	Organize learning events (to discuss key findings and recommendations, use the finding for planning of following year, etc)	Commissioning Organization	5	10/03/2019 – 25/03/2019

2.2 Evaluation questions

The key questions that need to be answered by this evaluation will be divided into seven categories of analysis. The seven overall evaluation criteria – relevance, effectiveness, efficiency, sustainability, impact, knowledge generation, and gender equality and human rights were applied for this evaluation (see Table 2).

Table 2. Final version of evaluation criteria and evaluation questions

Evaluation Criteria	Evaluation Question
Effectiveness	1. To what extent were the intended project goals, outcomes and outputs (project results) achieved and how?
Relevance	2. To what extent do the achieved results (project goals, outcomes and outputs) continue to be relevant to the needs of women and girls?
Efficiency	3. To what extent was the project efficiently and cost-effectively implemented?
Sustainability	4. To what extent will the achieved results, especially any positive changes in the lives of women and girls (project goal level), be sustained after this project ends?
Impact	5.To what extent has the project contributed to ending violence against women, gender equality and/or women's empowerment (both intended and unintended impact)?
Knowledge generation	6. To what extent has the project generated knowledge, promising or emerging practices in the field of EVAW/G that should be documented and shared with other practitioners?
Gender Equality and Human Rights	7. Cross-cutting criteria: the evaluation should consider the extent to which human rights-based and gender responsive approaches have been incorporated throughout the project and to what extent.

2.3 Evaluation aspects and methodology

Overall evaluation design:

For this evaluation, we used a mixed methods approach including quantitative and qualitative research methods. We used a medical and legal record review (quantitative), semi-structured interviews with PHR program trainees (qualitative), and administrative program data (quantitative) to triangulate program impact.

Table 3. Methodological aspects of the evaluation and corresponding descriptions

Methodological Aspect	Description
Evaluation design	We used a mixed quantitative and qualitative research methods strategy for this evaluation. The quantitative component included a pre-intervention, post-intervention two group (control, intervention) interrupted time series without random selection to evaluate the medical and legal records of survivors of sexual assault who were affected by PHR's program. Interrupted time series was used to evaluate the longitudinal effects of this time-delimited intervention. Further, we evaluated semi-structured interview data with trainees in the medical, law enforcement, and

Methodological Aspect	Description
	legal sectors (qualitative) to capture key implementation outcomes that mediate survivor impact. Finally, we used the prospective collection of administrative program data (quantitative) to triangulate outcomes examined in this impact analysis.
Data sources	Legal records of sexual assault, medical records of sexual assault, semi-structured interviews with PHR program trainees, and administrative program data.
Data collection methods and analysis	Legal and medical record archival data were collected retrospectively through systematic random sampling of cases by month, and were analyzed using segmented regression analysis of interrupted time series data, which allows for a statistical assessment of the level to which the intervention changed an outcome of interest relative to time. Semi-structured interviews with providers were conducted using a purposive sampling strategy and were analyzed using an inductive technique derived from grounded theory, where two levels of coding were conducted on transcripts produced from the audio-recorded interviews.
Sampling methods	We used target sampling to select intervention and control sites for medical and legal record reviews. Within a given site, we used systematic random sampling to select records for collection and analysis. We used a purposive sampling strategy to select participants for semistructured interviews. The apparent population of all PHR program data was captured with the administrative program data monitoring spreadsheets and pre/post training questionnaires that were prospectively collected throughout the course of PHR's program.
Field visits	Record reviews were conducted in Kenya, and semistructured interview data were collected on-site in Kenya and the DRC.

Evaluation methodology:

Table 4. Evaluation methodology

Sub-sections	Inputs by the evaluator(s)
Description of evaluation design	We used a mixed methods research strategy to triangulate the impact of PHR's program over the course of the grant period. The quantitative and qualitative components are each described separately, below. *Quantitative impact component* In order to evaluate whether the PHR program impacted the experiences of survivors of sexual violence, we evaluated the completeness of documentation, adjudication outcomes, and

	overall thoroughness of medical forensic documentation (which operationalize the program's goal) through medical and legal record reviews. This analytic strategy reduces potential negative consequences of the evaluation itself, where survivor-level outcomes can be ascertained without the risk of retraumatizing the survivor. We conducted a systematic review of medical and legal archives to assess how jurisdictional exposure to the PHR training program was associated with an impact on these survivor-level domains. This was done by evaluating an interrupted time series of select outcomes among case and control cases in jurisdictions relative to PHR program exposure. *Hypotheses* To evaluate the impact of the PHR program on medical and legal records for survivors of sexual assault in Kenya and the DRC, our hypotheses are: H1: Sexual assault cases occurring in jurisdictions with multi-sector actors who have been exposed to the PHR program will exhibit more complete medical and legal documentation in their case files in the years following exposure to the PHR program; H2: Sexual assault cases occurring in jurisdictions with multi-sector actors who have been exposed to the PHR program will exhibit more adjudication outcomes favoring the survivor of sexual assault; and H3: Sexual assault cases occurring in jurisdictions with multi-sector actors who have been exposed to the PHR program will exhibit improvements in the thoroughness of medical forensic documentation of sexual assault. We chose to conduct medical and legal record reviews given that the reviews would incur minimal risks and no additional burden to survivors of sexual assault. Medical and court records are entered into archives on a continuing basis as part of normal business operations (pre, during, and following PHR program exposure in a jurisdiction) and we aggregated data at temporal periods within sites (by month) to best determine how exposure to the PHR program may have affected case documentation and case outcomes relative to time in intervention and control sites. *Qualitative component*

To triangulate the effects of PHR's program, we also used semi-structured interviews with trainees in the medical, law enforcement, and legal sectors (qualitative) who received PHR trainings and participated in program activities throughout the course of the training. The use of semistructured interview data was meant to elucidate key aspects of the process of implementation that could promote and/or mitigate survivor impact. Interviewees answered key questions regarding their experiences with PHR's program, as well as the implementation of activities following program exposure.

Quantitative evaluation of program administrative data
Finally, prospectively monitored program tracking outputs and outcomes were also collected in a program record monitoring spreadsheet. The spreadsheet tracked programmatic activities over the course of the project, including: the training of colleagues; the development of Memorandums of Understanding with institutions; patient pathway and service assessments completed at health centers; the status of recommendation documents provided to health centers; the status of institutional plans that detail how institutions will integrate forensic training material into curriculums, protocols, practices, and in-service and pre-service trainings by project end; the status of agreements between PHR and selected institution; and the new research projects implemented by the program. The data were evaluated as part of this impact analysis to further triangulate overall program impact.

Data sources

This evaluation relies on five major data sources that were used to respond to the evaluation questions. In Table 4.1 below, we have specified the key data of interest, the corresponding instrument that was used to collect data, and a brief description of how that information was accessed. All data collection instruments are located in Annex 4 of this report.

Table 4.1 Data Sources

Key data of interest	Corresponding data collection instrument	How that information will be accessed
Legal records of survivors of sexual violence	Legal record review form	Through a systematic review of survivors' legal record
Medical records of survivors of sexual violence	Medical record review form	Through a systematic review of survivors' medical records

	Perspectives and behaviors of government officials, health professionals, legal officers, and uniformed personnel	Semistructured interview instrument	Through analysis of data transcripts produced during ongoing outcome evaluations collected during the course of the program
	Knowledge of PHR trainees relative to training	Pre/post training questionnaire	Through analysis of training data matrices that were maintained during the course of the program
	PHR activities over the duration of the project period	Program record monitoring spreadsheet	Through analysis of a program record monitoring spreadsheet that was maintained during the course of the program

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.)

Below, we separately describe data collection and analysis by quantitative and qualitative evaluation components, respectively.

RECORD REVIEWS (QUANTITATIVE)

Data collectors used legal and medical record review forms to conduct individual record reviews at intervention and control facilities.

Medical record review form
Medical record data were collected using a medical record review form (see Annex 4). The medical record review form contains items and questions that measured medical documentation completeness (pertaining to Hypothesis 1) and medical documentation thoroughness (pertaining to Hypothesis 3). Trained data collectors populated medical review forms for sampled records at intervention and control sites. The medical record review form contained 63 questions/items that measured completeness and thoroughness of the medical record. Individual direct patient identifiers (name, patient codes, etc.) were not recorded in the medical review forms, and responses were recorded in such a manner that the identity of the human subjects could not readily be ascertained directly or through identifiers linked to the patient for whom the medical record was being reviewed. In order to avoid paperwork burden and to increase data

	security, data were electronically collected on tablet devices and uploaded to a centralized server that used SSL encryption. *Legal record review form* Legal record data were collected using the legal record review form (see Annex 4), which contains items and questions that measured legal documentation completeness (pertaining to Hypothesis 1) and adjudication outcomes (pertaining to Hypothesis 2). Trained data collectors were tasked to populate the legal review forms for sampled records at intervention and control sites. The legal record review form contained 87 questions/items that measured the completeness of the legal record, and corresponding adjudication outcomes. Individual direct identifiers (name, court-assigned codes, etc.) were not recorded in the legal review forms, and responses were recorded in such a manner that the identity of the human subjects could not readily be ascertained directly or through identifiers linked to the individual for whom the legal record was being reviewed. In order to avoid paperwork burden and to increase security, data were electronically collected on tablet devices and uploaded to a centralized server that used SSL encryption. *Quantitative data analysis* Record review data were analyzed in Microsoft Excel and STATA 14 statistical software. Record review data were collapsed by month relative to the PHR intervention month. We used multiple-group interrupted time-series analysis, which allows for the inclusion of a control and intervention group. The multiple-group regression model is an expanded version a single-group time series analysis.[1] The regression model for the multi-group analysis is: $$Y_t = \beta_0 + \beta_1 T_t + \beta_2 T_t + \beta_3 X_t T_t + \beta_4 Z + \beta_5 Z T_t + \beta_6 Z X_t + \beta_7 Z X_t T_t + \epsilon_t$$ Where Y_t is the aggregated outcome variable measured at each equally spaced month t, T_t is the time since the start of the observation period, X_t is a dummy variable representing intervention period, $X_t T_t$ is an interaction term, Z is a dummy variable representing cohort assignment (intervention, control), ZT_t, ZX_t, and $ZX_t T_t$ are interaction terms. The value of β_6 indicates the differences between control and intervention groups immediately following introduction of the PHR intervention, and β_7 represents the difference between the intervention and control group slopes after the intervention compared to preintervention

[1] Ariel Linden. Conducting interrupted time-series analysis for single- and multiple-group comparisons. The Stata Journal (2015), 15, Number 2, pp. 480-500.

	slopes. Presuming an AR(1) process, the random error is presumed to follow: $\epsilon_t = \rho\varepsilon_{t-1} + u_t$. We aimed to reduce the threat of confounding by sampling control sites from a jurisdiction in Kenya that was relatively comparable to Nakuru, but where practitioners were presumed not to have been exposed to PHR program activities nor training. Coefficients were estimated using OLS regression with Newey-West standard errors to handle autocorrelation in the data. We did examine the first six autocorrelations in each series using the Cumby-Huizinga general test for autocorrelation, however autocorrelations were rare and where they were apparent generally followed a first-order process. While we generally focus on immediate post-program exposure effects in the Effectiveness and Impact sections of this report, we talk about post-exposure *trends* in the Sustainability section of this report. Given that this was a program evaluation, we did not draw cutoff values for statistical significance, but rather examined effect sizes relative to measures of effect size variability taking into account that program resources were not being diverted to necessarily establish statistical significance. SEMISTRUCTURED INTERVIEWS (qualitative) While the PHR program focused 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, best practices may have been implemented in a real occupational setting and how forensic evidence of sexual assault was actually obtained.

	Throughout the course of the UNTF grant, qualitative semi-structured interviews (see Annex 4) were collected with PHR trainees in Kenya and the DRC to evaluate UN Evaluation Group impact evaluation domains that appear in this current impact analysis. The semistructured interview guides were developed to address the effectiveness, relevance, efficiency, sustainability, perceived impact, and knowledge gained from the PHR program. Interviews occurred in private locations out of earshot range of other individuals. All interviews were audio-recorded. *Qualitative Data Analysis* Following transcription of the audio recording, each interview transcript was subject to qualitative analysis using an inductive approach derived from a grounded theory framework. Here, codes were developed to specifically match semistructured interview responses with UNEG domains (e.g. efficiency, sustainability). Generally speaking, coding refers to the process of combing the data to identify categories of themes and ideas and then marking similar passages of text with a "code." To conduct this type of analysis, we first subjected all interview data to open coding (present progressive summations of text). Next, we grouped open codes into axial codes that corresponded to UNEG domains. Atlas.ti was used to code qualitative data. ADMINISTRATIVE PROGRAM DATA Throughout the course of the program, pre and post training questionnaires and program record monitoring spreadsheets were maintained to prospectively track program activities. While these instruments do not form the core of this impact evaluation, they do provide useful information for some of the core UNEG domains. Trainee interview questionnaires and program monitoring spreadsheets were examined for basic distributions relative to the PHR program period of interest.
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,	PHR program activities pertinent to this impact analysis were conducted in Kenya and the DRC from 2015 to 2018. In Kenya, the program is geographically focused in the Rift Valley region, Kisumu, Eldoret, and Nairobi. In the DRC, the program is focused in the eastern region of the country (North Kivu and South Kivu). Reviewing the program's targeted beneficiaries, approximately 15,000 primary beneficiaries (women/girl survivors of violence) were expected to be reached within the target area through their interactions with secondary beneficiaries (550). In the qualitative component of this evaluation, we used a purposive sampling strategy to generate a sample of secondary beneficiaries to report on their experiences (both with PHR and

human rights treaties, gender statistics, etc.)

with primary program beneficiaries) as part of PHR's ongoing outcome evaluation activities conducted during this course of this grant period. In the quantitative study, we focused on jurisdictions within Kenya's Rift Valley region to examine receipt of medical forensic evidence in healthcare facilities and in the broader multisectoral environment. We focus on the Rift Valley region due to quality and access of records, safety of the data collection team, as well as logistical feasibility in implementing this type of investigation. Further, this type of analysis allows for the collection of control sites to make for a more rigorous evaluation (as opposed to just using pre/post estimates without controls, which is how we would have had to assign resources if we conducted record review analyses in both countries). While the qualitative sampling component covered both of the program's regions in Kenya and the Eastern DRC, the quantitative sampling component was a target sample of Kenyan facilities in the Rift Valley region of Kenya. This mixed methods evaluation strategy thus achieves breadth and depth. More information pertaining to quantitative and qualitative sampling strategies is provided below.

RECORD REVIEW SAMPLING (QUANTITATIVE)

For the legal and medical record reviews, we first target sampled jurisdictions in Kenya to select intervention and control facilities. We chose this particular region due to the quality of medical records, feasibility and safety of the data collection team to arrive, and relative capacity of institutions. Two healthcare facilities (one intervention, one control) and 2 courts (one intervention, one control) were sampled. The sites are illustrated in Table 4.2 below.

Table 4.2. Control and intervention sites for the medical and legal record reviews

	Medical Record Review	Legal Record Review
Intervention jurisdictions	Rift Valley Provincial General Hospital	Nakuru Law Courts
Control jurisdictions	Kibera South Hospital	Kibera Law Courts

One strength of the target sampling strategy is that medical and legal records occur in the same jurisdiction for intervention sites, and separately for control sites. Thus, gains in the medical sector would theoretically appear in legal sector records within the same jurisdiction, and the opposite would be true for the control sites (leading to less contamination by control or intervention site conditions). Further, sampling in this manner could reduce error

	in time characteristics for the control site, such that the intervention period for the PHR program in Nakuru (October 2017) could be standardized to all intervention and control sites. Within a given site, it was necessary to determine the number of months for which records occurring prior to the PHR intervention that would to be sampled, along with the number of months following the PHR intervention. Based on simulation results reported in the peer-reviewed literature, segmented time series regression models can have >80% power to detect effect sizes of ≥ 1.0 in scenarios with ≥ 24 time points.[2] Zhang et al report that a sample of 36 time points with one-third of the sample in the post-intervention period, with an effect size of 1.0 and an autocorrelation of ≤0.1, the estimated power of 0.72 increases as autocorrelations decrease. After examining PHR's 2015 medical record review data for high vaginal swabs in Kenya, the autocorrelation fell into this range and we would expect similar autocorrelations in this upcoming evaluation. Thus, within a given facility (legal or healthcare), 24 observation periods *before* and 12 observation months *after* the intervention were selected, centered on the date of PHR program exposure, generating a sample of 37 time points by site. A trained team of data collectors conducted the medical and legal record reviews at healthcare and legal facilities in Kenya. At all sites, the population of medical records was first stratified by date, beginning with records appearing at the site in October 2015 and ending with records appearing at the site in October 2018. While PHR had historically conducted other programming activities in Nakuru prior to the defined intervention date, the current program did not begin implementing activities in Nakuru until after an extensive nurses' strike. The intervention month, October 2017, was thus the index month of the PHR intervention in Nakuru (when programming was implemented in earnest) and we used the same corresponding time period for the control site analyses. Within each month, a sampling interval was determined by dividing the overall number of records by 3. A random start was used to determine the selection of the first record within a given month, and 2 additional records were selected for that month. A given site could thus have a potential maximum of n=111 records representing 24 pre-intervention months, 1 intervention month, and 12-post intervention months. In sum, record review sites were selected using target sampling, and records within sites were selected using systematic

[2] Zhang F, Wagner A, Ross-Degnan D. 2011. Simulation-based power calculation for designing interrupted time series analyses of health policy interventions. Journal of Clinical Epidemiology.

sampling with a random start. Further, it is generally recommended that for interrupted time series analysis, there are at minimum 12 observation points during and 12 observation points following the intervention, allowing for an adequate assessment of both level and trends associated with the exposure period.[3] We expanded these parameters to include a larger span (37 months versus 24 months) given power simulations in the literature. Thus, our analyses were adequately powered to detect intervention effects.

SEMISTRUCTURED INTERVIEW SAMPLING (QUALITATIVE)

We used a purposive sampling strategy to generate the qualitative sample of semistructured interviews. Semistructured interviews were collected once in 2016 (n=43) and once in 2018 (n=44) to gauge programmatic outcomes as the program was implemented, capturing key UNEG domains at both time periods across Kenya (n=57) and DRC (n=30). Of the 87 interviews conducted, individuals from the healthcare sector were overrepresented (n=50, 57% of qualitative sample) because they were the most targeted type of secondary beneficiary. A distribution of semistructured interviews conducted by sector, country, and year are shown in Table 4.3 below.

Table 4.3. Semistructured interviews by sector, year, and country

Year	Sector	DRC	Kenya	Total
2016	Healthcare	7	14	21
	Law Enforcement	3	6	9
	Legal	6	7	13
2018	Healthcare	7	22	29
	Law Enforcement	4	4	8
	Legal	3	4	7
Total		30	57	87

Limitations of the evaluation methodology used	The retrospective record reviews, semistructured interviews, and programmatic data relied upon a quasi-experimental design, and as such a determination of the effect sizes associated with

[3] Wagner A, Soumerai S, Zhang F, Ross-Degnan D. Segmented regression analysis of interrupted time series studies in medication use research. Journal of Clinical Pharmacy and Therapeutics (2002) 27, 299–309

	program impact are approximate estimations that reflect these design limitations. Further, we did not interview survivors directly about their experiences with service providers and/or broader community, institutional, and social elements that would be affected by the program. However, our design methodology was chosen as it can feasibly evaluate impact on services provided to survivors without asking survivors to recall events related to their experiences as survivors of sexual assault (which could be unnecessarily traumatic).[4] Finally, the control sites in Nairobi had been exposed to MSF and AMREF programming, but this exposure was not substantively focused on implementing improved forensic practices. As such, the limitations reflect our assessment of conducting a feasible and ethical evaluation in the context of this program.

2.4 Evaluation safety and ethical protocols and considerations

Safety and ethical protocols:
At the outset of the impact analysis, the evaluation team reviewed the UNEG Code of Conduct for Evaluation in the United Nations Systems and designed this evaluation protocol to meet the ethical standards detailed therein. Further, the instruments and methods associated with the impact evaluation protocol (namely the record reviews) were submitted, reviewed, and approved by Georgetown University Institutional Review Board (protocol 2018-1046) on October 9, 2018. Further, ongoing PHR outcome evaluation activities (program record review database, pre and post-test questionnaires, semi-structured interviews) were submitted, reviewed, approved, and received continuing review and approval from the Georgetown University Institutional Review Board in a separate protocol for those activities (protocol 2016-0661). Both protocols were designed to collect evaluation data with this UNTF-sponsored impact analysis in mind. Thus, all impact evaluation activities for this current protocol have received ethics review and oversight from the Georgetown University Institutional Review Board. We also received local approval from the hospitals and courts, as well as Nairobi County.

Safety and ethical considerations:
Data collectors conducting record reviews were visiting courts and healthcare facilities to collect data. They reviewed paper records and entered select information into an electronic interface where record data were stored. Data were directly entered into tablet devices using a survey software program. Thus, if someone were to pick up the tablet the data would not be apparent/readily retrievable and data safety would not be compromised. Data were uploaded to a centralized server that was protected with SSL encryption. All data were entered directly into the

[4] Anastario, M. Medical Record Review and Evidence of Mass Rape during the 2007-2008 Postelection Violence in Kenya, in Gender Violence in Peace and War: States of Complicity. Eds. Victoria Sanford and Katerina Stefatos. 2016; Rutgers University Press, New Brunswick, New Jersey. p.85-101.

tablet device, in a data administration format that is akin to computer assisted self-interview (but in this case, no individual was being interviewed. Rather, data elements were being extracted from an existing record and input directly into an electronic interface).

This was a minimal risk study. The risk for adverse events to occur was highly limited given that data were collected and entered into a tablet inside of healthcare facilities or courts. Given that only archival data was being collected and entered into a relational database, data collector safety in the Rift Valley region was not a particular issue given the study design and data collection modalities considered.

All record review data were SSL encrypted. Data collectors attended a training and were trained in confidentiality techniques, including protecting the privacy of records. The Android tablet devices that were used for data collection were password protected and were not used for any other purposes. The survey software was loaded onto the tablet devices, and individual survey responses were not apparently extractable from the app itself. Only members of the data collection team had access to the android tablet devices, which were password protected. During data collection, tablets were managed by PHR program staff who maintained a registry of users. Data were only stored locally when the android tablets are not connected to the internet. As soon as the data are uploaded, the data files are deleted from the local survey software app.

Data were entered into the survey software using a computer-assisted self-interview platform, on an item-by-item basis. Once the record was fully entered, it was not visually retrievable through using the app (as opposed to paper, where a physical record continues to exist and can be seen by anyone who has exposure to the paper file). Individual items were stored locally in the app in a relational database that is not visually retrievable by the data collector nor any standard user of the android tablet following record entry. Data were stored locally until the device was connected to the internet. Data were downloaded from the secure server onto a password protected computer. The analytic data was compounded into frequencies by month. Thus, the analytic dataset was not at the survivor-level. This time series dataset is what was used by the study team to conduct the program evaluation.

All qualitative interview data with PHR-trained physicians, law enforcement personnel, judges and legal professionals, along with all programmatic data, was already collected as part of the program's ongoing outcome evaluation and has been de-identified and coded. Participants who participated in the semi-structured interviews provided informed verbal consent prior to participating in interviews.

3. Findings and analyses by evaluation question

3.1 Effectiveness

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	The program's focus and investment in training and capacity building activities produced outputs that include knowledge acquisition and institutional changes. Program outcomes are focused on professionals utilizing knowledge and skills to build collaborative networks and implement best practices in the service of survivors. These changes are aimed at the overall goal of survivors receiving improved services that make justice more accessible. The effectiveness section of this evaluation is focused on knowledge acquisition and behavioral changes in the complex multisectoral contexts of the DRC and Kenya over the course of the program period. It includes an analysis of survivor-level outcomes that would have been implemented by PHR trainees, as reflected in the medical and legal records of survivors of sexual assault. *Multi-sectoral effects that implicated survivors* Beginning with survivor-level outcomes, which for this effectiveness section of the impact analysis are focused on documentation completeness in the medical and legal records, the PHR program was associated with significant quantitative impacts in areas that require cross-sectoral collaboration. Significant quantitative increases in medical record documentation of whether the incident was reported to the police, medical record documentation of informed consent, and the increased presence of P3 forms and PRC forms in the legal records in the period immediately following the PHR intervention period were detected. These changes are multisectoral in nature. A PRC form appearing in a legal record requires a physician to fill it out for it to be effectively utilized in the legal sector. Advocacy efforts surrounding documentation issues in sexual assault cases relied on actors working together across sectors to identify and advocate for these changes that otherwise mitigate justice accessibility for survivors. There were variable findings regarding the sustainment of these quantitative effects throughout the course of the post-intervention period, which may be mitigated (as evidenced in the qualitative analyses) through personnel transfers following the training, and the need for individualized technical assistance to incorporate highly technical information into everyday practice (a useful, albeit costly and infeasible solution in this context). The program's development over time began to focus not

	only on more advanced and specific material, but in training local providers who could fill such gaps. *Kenyan medical sector effects* Qualitative evidence further reveals particular effects associated with the program on secondary beneficiaries' behaviors in their everyday occupational settings that are not readily captured by quantitative measures in a record review. Qualitative data in Kenya suggest increased attention to patient privacy and confidentiality, and emphasized importance of a complete and thorough PRC form in the medical sector. In later stages of the program in Kenya, participants described receiving and co-training in advanced pediatrics trainings that resulted in self-reported alterations in the provision of more child-centered care and the dissemination of best practices in medical settings. *Kenyan law enforcement and legal sector effects* Increased attention to the medical needs of survivors among law enforcement sector participants corroborate the quantitative medical record findings of increased documentation of whether the incident was reported to the police in the medical record. Improvements in PRC documentation reported in the judicial sector corroborated increases in P3 and PRC forms occurring in legal records in a PHR program area compared with controls. *DRC medical sector effects* Qualitative data in the DRC suggest uptake in the forensic certificate, more thorough examination practices, the uptake of forensic photography, and the receipt and implementation of pediatric speculum use to provide more survivor-centered care, treatment, and examinations in the medical sector. Curriculum companions provided by PHR were described as useful references in sustaining best practices in occupational settings following the training. Participants in the DRC in particular described that experiences with PHR training filled gaps in forensic medicine that were perceived as missing from standard Congolese medical education (among the interviewees interviewed). *DRC law enforcement and legal sector effects* Law enforcement sector participants described increasing their attention to forensic evidence in sexual assault cases, and recognized PHR's role in the development of the forensic certificate and corresponding medical lexicon. PHR's support of advocacy efforts to adopt the forensic certificate reinforced participants who increased their attention to adequately completing forensic certificates,

	realizing that forensic certificates (in the absence of DNA analytic capacity in the eastern DRC) could provide some of the most probative evidence in sexual assault cases. *Summary* These local changes in professionals' knowledge and occupational practices, along with structural efforts made with program support to better facilitate documentation for survivors, have implications for the services provided to sexual assault survivors. Based on pre-training questionnaires and secondary beneficiary counting, it is estimated that those behaviors may reach approximately 18,261 survivors receiving services from secondary beneficiaries interacting with the PHR program.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	The evidence gathered to address the effectiveness evaluation criteria was both quantitative and qualitative. Quantitative data in Kenya included medical and legal record reviews, as well as estimates derived from program data including pre-training questionnaires. Qualitative data were derived from the experiences of healthcare, law enforcement, and legal sector trainees and program participants in conducting investigations and in providing services to survivors of sexual assault. Record review findings are presented first, followed by qualitative data findings and finally, estimates derived from programmatic data. QUANTITATIVE EVIDENCE FROM MEDICAL AND LEGAL RECORD REVIEWS Select items from medical and legal record reviews were examined to determine whether the program was associated with an improvement to documentation quality. Improvements in documentation quality reflect both a change in trainee behavior, and may help a survivor receive better care, treatment, and services in the multisectoral environment (including building a stronger case). Medical record documentation quality variables that were analysed for the effectiveness section of the evaluation included whether: *The date of birth was documented,* *Date and time of the incident was documented,* *The number of perpetrators was documented,* *The age of the perpetrator was documented,* *The location of the incident was recorded,* *The chief complaint "incident" section was filled out,* *Condom use was documented,*

	There was documentation of the incident being reported to the police, *Pregnancy was documented,* *Pulse rate documented,* *Respiratory rate was documented,* *Temperature was documented,* *The survivor used the toilet was documented,* *The survivor left marks on the perpetrator was documented,* *Name and signature for examining officer was documented,* *Date for examining officer's signature was present,* *Name and signature for police officer was present,* *Date for police officer's signature was present, and* *Whether there was documentation of informed consent.* Legal record documentation quality variables that were analysed for the effectiveness section of the evaluation included whether: *The date of the assault was reported,* *The number of assailants was documented,* *A charge sheet was present,* *The date of the conviction was present,* *A photograph of the convict was present,* *A P3 form was present,* *A PRC form was present,* *Forensic photography was present,* *A report from the government chemist was present, and* *A parental statement for the child's age was present.* Tables A1-A6 at the end of this section illustrate results from the multiple-group interrupted time-series. The vast majority of medical record and legal record outcomes examined showed positive improvements across items in the period following the PHR intervention (See Tables A1-A6). Appreciable effects were observed for increases in the documentation of whether the incident was reported to the police in the medical record, documentation of informed consent in the medical record, and the presence of P3 and PRC forms in the legal records in the period immediately following the PHR intervention period. *Documentation of whether the incident was reported to the police in the medical record (Table A2)* As shown in Table A2, the initial mean level difference between Nakuru and Kibera was not significant, nor was the difference in the mean baseline slope, suggesting comparability of the control and intervention cohorts on documentation of whether the incident was

	reported to the police in the medical record. There is a statistically significant treatment effect during the first intervention month (+0.31 percentage point increase in documentation of whether the survivor reported to the police). Further analysis revealed a slight decrease in the postintervention period among Nakuru cases by -0.02. *Documentation of informed consent in the medical record (Table A4)* As shown in Table A4, the initial mean level difference between Nakuru and Kibera was not significant, nor was the difference in the mean baseline slope, suggesting comparability of the control and intervention cohorts on documentation of informed consent. There is a statistically significant treatment effect during the first intervention month (+0.68 percentage point increase in documentation of informed consent). *The presence of P3 forms in the legal record (Table A6)* As shown in Table A6, the initial mean level difference between Nakuru and Kibera was not significant, nor was the difference in the mean baseline slope, suggesting comparability of the control and intervention cohorts on the presence of the P3 form in the legal record. There is a statistically significant treatment effect during the first intervention month (+0.50 percentage point increase in P3 forms being present in the legal record). Further analysis revealed a slight decrease in the postintervention period among Nakuru cases by -0.03. *The presence of PRC forms in the legal record (Table A6)* As shown in Table A6, the initial mean level difference between Nakuru and Kibera was not significant, nor was the difference in the mean baseline slope, suggesting comparability of the control and intervention cohorts on the presence of the PRC form in the legal record. There is a statistically significant treatment effect during the first intervention month (+0.37 percentage point increase in PRC forms being present in the legal record). QUALITATIVE EVIDENCE FROM SEMISTRUCTURED INTERVIEW DATA Qualitative interviews were conducted with training and program participants in 2016 and 2018. While 2016 interviews focus more on the multisectoral trainings, the 2018 interviews focus on more advanced, specialized trainings that the program implemented. These advanced trainings include efforts to train local, in-country staff to further deliver training material. The effectiveness analyses thus

	focus on trainees' experiences with these evolving training efforts throughout the life course of the program in both countries. *Kenya* In the earlier stages of the program in Kenya in 2016, interviewees described changes in practice across the medical, law enforcement, and legal sectors. Here, we focus on changes made internally in each respondent's agency or department. While most of the information regarding a given sector was derived from individuals within that sector (physicians speaking for the medical sector, for instance), it is often the case that individuals from other sectors can provide important insight. For example, prosecutors had an advantageous perspective on how police officers work to collect and preserve evidence. Medical sector In the earlier stages of the program in Kenya, the most significant changes for medical professionals included the nature and scope of the forensic exam. This specifically included a more comprehensive examination methodology and more frequent use of the PRC form for sexual assault cases. These changes were attributed to PHR's training activities because many medical professionals said that PHR training on the PRC form provided a new understanding of their role in evidence collection and survivors' access to justice. By learning, and witnessing, that their position is only a part of a larger intersectoral effort against sexual assault, healthcare professionals described being more motivated to collect probative evidence. Healthcare providers also described providing more thorough emergency medical treatment for the survivor. Learning about and focusing on one's role in intersectoral collaboration had other effects, and as such it is a theme that will be repeated throughout the findings of this report. Specifically, medical professionals described changes in how they conduct forensic exams and in how they collect evidence. Before PHR training, many medical officers conducted examinations of survivors that would focus on a visual exam of the survivor's genital areas, specifically their hymen. Whether or not the hymen was attached/perforated was often used as the most probative evidence in determining whether or not an individual, usually a minor, was raped. For cases of attempted rape and cases where other physical injuries have healed, it was difficult to prosecute the perpetrator given reliance on medical documentation of the hymen. However, in accordance with the PRC form, medical officers are now conducting what one doctor described as a "head-to-toe" examination, which broadens the scope of the exam and documents a much wider range of bodily injuries. One nurse described the

	purpose of the forensic exam as "not just to look for hymenal tears but even other minor injuries that will assist as evidence for sexual injury." Another major benefit of the PRC form, as opposed to the P-3 form only, is that it contains information that can assist the prosecution in corroborating the testimony of the survivor and other witnesses. Clinicians began using forensic photography following the PHR training in order to document injuries to the patient's body. This is especially important because in the time that it takes to get a court case to trial, many injuries have healed or are no longer visible. The photographs were described as being a better method of documenting the severity of the injuries. Medical professionals had mixed opinions regarding their use of photography in forensic exams. Some clinicians thought it was unnecessary or would pose a violation of privacy on the part of the survivor, especially minors. Others thought it was a crucially important part of the exam. However, access to cameras is limited. A few medical officers indicated that they use the camera on their smartphones to document injuries - only after getting patient consent and with the condition that the photos would be deleted. How these electronic images are stored or how they are admitted into evidence is unclear. Some interviewees said that they were not admissible in court and others indicated that they were. Another important change in the practices of healthcare professionals concerns patient privacy and confidentiality. Specifically, significant efforts have been made to provide physical space in healthcare facilities for examinations and interviews of sexual assault survivors. Healthcare professionals described conducting a forensic exam while people walk through the room, or conducting sensitive intake interviews in crowded rooms, sometimes in full view of the perpetrator. The new spaces that have been arranged in healthcare facilities are usually rooms that can be locked from the inside and are not part of main pedestrian thoroughfares where interviews can be interrupted and overheard. In fact, several evaluation interviews were conducted in such spaces, which usually consisted of an exam bed and one or two chairs. This enhanced sensitivity for privacy also extends to the storage of patient records. New protocols have been put in place in some facilities to limit and monitor access to confidential patient records. These changes were all made under the auspices of protecting sexual assault survivors, their dignity, and protecting the information that is most relied upon in court. In regards to the PRC form and patient referrals, a few medical professionals discussed how they have changed the process for referring patients to psychological or psychiatric treatment. The PRC was described as collecting key indicators related to patient's

	mood, speech, and other indicators of trauma and shock. These professionals agreed that psychological and psychiatric support is vital for the ongoing recovery of sexual assault survivors, but questions remain in how psychological indicators are collected by the PRC form, and who is qualified to fill it out. In some facilities, Part A (medical) of the PRC form is filled out by one official and Part B (psycho-social) is completed by another. Some suggest that this ensures the most qualified person is completing each part and others fear that multiple people filling out the same form increase the likelihood of the form getting lost or compromised. Prosecutors value this psycho-social data because it can be used to demonstrate the more long-term effects of sexual assault - which is a key piece of evidence being used in criminal sentencing. In court, medical professionals normally provide key testimony in sexual assault cases. Their testimony is used in validating the results of forensic exam and in verifying the identity of the patient/ survivor. In fact, without medical expert testimony, it is almost guaranteed that the case will be dismissed. In years past, medical professionals considered this process to be a string of antagonistic interactions and they often felt that they themselves were on trial. However, consistent use of the PRC form has made court testimony easier to give because, as they suggest, evidence is clearly documented and more difficult to challenge by defense attorneys. Medical professionals consistently acknowledged that the PRC form allows them to be more confident in their court testimonies. Specifically, they feel less vulnerable to criticism by the defense, who often disparage medical witnesses with questions like, “How can we know if you are really a doctor?” or “Do you even know how to conduct a post-rape exam?” One clinician noted, “When you have documented everything, and you have collected your evidence adequately, it becomes easier. It only becomes a problem when you have not collected it or have not documented it adequately.” The obstacles to effectiveness that medical professionals face are closely related with the structural issues that limit accessibility to material and economic resources among healthcare facilities and government agencies in Kenya. These issues include a lack of human resources, material resources, and the frequency in which individuals from all three sectors are transferred to other locales. Often, clinicians are transferred to other institutions and these individuals are subsequently replaced by a someone who has not been trained by PHR. As one nurse explained in regards to the untrained personnel being transferred into the region, “we are back to our old ways.” It was common to hear a medical respondent make a statement like, “... there was six of us who went to PHR training and now I am the sole remaining.”

	In the latter stages of the program in Kenya, PHR had developed, implemented, and worked with local physicians on becoming future trainers for an advanced pediatrics training (APT) in Kenya. Participants of the APT described making changes to and attempting to improve the child-centeredness of care and treatment provided to child survivors of sexual violence. Trained providers described altering care, treatment, and documentation practices following training, and provided several examples of perceived impact on individual survivors. Providers also commented on the utility of the standardized patient as an andragogic technique that impacted providers' behaviors following the training. ***Child-centeredness*** Following the APT, healthcare providers described alterations in their general approaches to child survivors of sexual assault, including the amount of attention and time provided to conduct exams with patients, healthcare facility spatial dynamics, and psychosocial issues surrounding child sexual assault. Providers described increasing their general level of patience with and time allotted to the exam and documentation of child sexual assault survivors, which in turn resulted in the provision of more time to obtain narratives from children. Providers also described implementing changes to the physical spaces provided to child sexual assault survivors who present to their healthcare facilities. Some providers described how the examination rooms used for child cases were inadequate or uncomfortable for children. Following the APT, some providers began ensuring that toys and/or arts & crafts materials were available for children to play with in relatively isolated spaces at the healthcare facility, such as private consultation rooms. The purpose of attempting to provide such options/spaces for children was to increase their overall level of comfort. One APT trainee described how children like a friendly room because they need something to play with. If he comes [to] a room like this one…children need attractive colors in their rooms. Red, flowers, dolls, and etc. So since then, some of the materials you are given by the child--they are still in my room whenever I have such a case who can give a child drawings, something we didn't know before about the kids. And through that child would feel friendly, like my relative. Yeah, it will give you the story, he'll answer you your questions. You'll be free to draw what happened. Sometimes we tell them to draw what happened. From their drawing you can learn something from their brain.

	Providers described an increased amount of attention given to the psychological issues that arise in child sexual assault survivors and remained attentive to gaps in the documentation of mental health issues (part B of PRC form) and the provision of follow-up psychosocial services to child sexual assault survivors. Some providers described initiating follow-up sessions for child survivors that were specifically devoted to the psychosocial issues in an assault case. Some participants expressed the desire for more training regarding psychological issues that arise in child sexual assault cases, including assessment and documentation procedures. General attitudinal changes of providers were also described as moderating changes in the provision of child-centered care following the advanced training. Providers described being personally more attentive to the safety of the child and being more attentive to the presence or absence of a parent as it concerns the alleged perpetrator. Some providers described alterations in attitudes following the APT, such as changing the way they might orient themselves to a new child sexual assault case prior to the APT (e.g. blaming parents for negligence), to their post-APT orientation (e.g. centering attention on the child and altering examination and documentation practices). Following the APT, providers described perceptions of increased self-efficacy in examining child sexual assault cases, as well as an increased capacity to build physician-client trust with child survivors. ***Evidence and documentation practices*** Providers described changing their documentation practices in child sexual assault cases relative to the APT, and focused on ways that that their obtainment of the child's narrative has changed in practice. One participant summarily described that his documentation practices in child cases were haphazard prior to the APT, but more systematized following training. One provider who described paying extra attention to the child's narrative relative to parental presence described how during the APT I remember there is a case whereby the child was defiled by the parent. And then when the parent is inside the room, then the child tells you a different story. Then later the caretaker comes outside and the child now tells you the real story. So even when I'm seeing the child in my facility, I would first get the history from the child. If only he is comfortable to give the story while the caretaker is outside. He'll give you the real story. Then later you can invite the mama or the caretaker in. But one thing you need to reassure the child is that you are not going to tell the

	story to the caretaker. So that was something very important that I learned. One of the more effective changes that was described as stemming from the training was learning to manage the caretaker/guardian of the child who accompanied the child to the healthcare facility. This involved asking the child about whether the parent should be present during the exam and learning to ask the parent/caretaker/guardian to leave in order to elicit less biased narratives from the child. This was described as not only being important in cases where the parent/guardian could be a potential perpetrator, but also in eliciting more truthful responses regarding peer sexual contacts (particularly if the contact was consensual) that a minor may not want to openly express in front of a parent. In one such case, a parent provided a narrative that was documented by the police, but that did not reflect the narrative provided to the clinician when the child had been separated from the parent. As a result, the clinician had to communicate with the police to ensure that the parental narrative was not being documented as the child's narrative due to conflicting accounts of the incident. Parents were described as sometimes being a barrier to conducting adequate forensic exams with children and may (for a range of reasons including potential perpetration, shame, anxiety, etc.) pressure the clinician to expedite an exam with a child sexual assault survivor. As such, learning to ask the parent to leave the room was something that was not only described as helpful to current examination behaviors enacted by APT trainees, but also something that was practiced with standardized patients and thus easier to implement following the advanced training. Trained providers described recognizing the value of children's narrative and acknowledged that children may tell different stories to different people on different occasions. Finally, providers also focused on the need to obtain consent prior to conducting exams on children following the APT. Beyond changing the conditions that affect the elicitation and documentation of the child's narrative during the exam, trained providers also described altering their physical examination and documentation procedures. Participants noted that materials distributed by PHR were useful and put into practice for this purpose. Some participants began using chain of custody forms following the training, and some reported photocopying the chain of custody forms that were distributed. Similarly, some participants described using the khaki envelopes that were distributed by PHR, and described changing their evidence packaging behavior following the APT. One provider described that the pediatric speculum provided by PHR was the first they have had in their healthcare facility, and others commented that the distributed flashlights have

already been used. On a related note, participants described that having the judicial sector participants present at the APTs was useful because judges could comment on how physicians document evidence in ways that are problematic that were altered following the APT.

Utility of standardized patient as andragogical method

Overall positive feedback was received regarding the use of the simulated/standardized patient in APTs. Following APTs, standardized patients were perceived to have mnemonic/recall value, where physicians described reflecting on the standardized patient at the moment they were presented with new patients in practice. One physician described the cognitive link between the "remembered" APT standardized patient and a real patient who presented in practice following the APT:

> The standardized patients have been trained to present certain challenges that are practical. So, when you meet a real-time patient, I've had scenarios where my mind goes to what I encountered during the standardized patient workshop, and sort of you'd quickly try to think how you went through that and it somehow gives you some results… I'll give you this example, one standard patient - when we were training…could not totally open up. And at that point, one of the trainers suggested that we involve someone of younger age, same gender, in the room, someone like a social worker. So, when that happened, she opened up and we got the information that we're looking for. Now, when I met a patient, real-life, a patient who was totally not talking, I sort of thought…I will need someone else, a social worker, and luckily, I had a nurse who had trained in counseling and all that, so when she came in and took some time with her [the patient], she [the patient] opened up and then I was able to get history. Yeah. Initially, before all this, when a patient would come and refuse to talk, I would abandon the whole thing, yeah, and tell them, "Come when you're ready to talk," and I realize that was the wrong approach. So, this sort of made me know how to handle such kind of situations.

Physicians described the mnemonic/reflective process of the standardized patient as helping them slow down and allot adequate time to address child sexual assault survivors in practice. General comments were made about the standardized patients being

somewhat comprehensive, where the range of possible scenarios encountered in practice were perceived to have been adequately simulated during the APT standardized patient sessions. Some perceived the standardized patient to be the most important part of the APT. Additional comments were made that the standardized patient did a good job with his/her acting during the training.

Dissemination

Several members who attended the APT described disseminating best practices to colleagues through collaboration, mentorship, and abbreviated instructional sessions regarding program content. Dissemination efforts will be more fully addressed at a later section in this report regarding Training of Trainers and mentorship. Briefly, it is important to note that APT trainees did in several cases describe disseminating key lessons from the PHR APT during brief continuing medical education (CME) sessions and through intersectoral case processing interactions with members of law enforcement. CME sessions were typically short presentations (occurring over the course of a few hours in a single day) with colleagues or advanced medical students and residents. Several trainees described educating the police (subsequent to the APT) on specific cases as they arose in practice, including instructing the police on a case-by-case basis to take more time to obtain the child survivor's narrative and in providing additional attention to having the police follow-up on child survivor cases. One physician described

> I remember there was a case whereby we took time to examine that child, so we got all of the permission from the child. And then when the child went to the police, he couldn't talk so they started relying on the information. And the information the mother was giving was different from what the child had given us. So, the police officer had to call back…and inquired who gave the information. I told him he need to take time with that child because he may open up and tell you what happened.

As it regards the sustainability of the APT, it was described that the APT should be integrated into medical school curriculums in Kenya. This was primarily described as pertaining to undergraduate medical school curriculums, but could also apply to advanced medical training (such as residents in Obstetrics and Gynecology). To get this type of effort moving, it was described that university leadership (e.g. the dean, the chancellor of the university) need to be engaged in addition to the Ministry of Health and the Ministry of Education. One provider described PHR's attention to building a healthcare

	facility-based center of excellence and asked for the same type of momentum to be applied to integrating APT curricula into medical schools: > They're trying to sort of establish a center of excellence in matters to do with gender and sexual violence, and they're working hand-in-hand with the ministry of health and trying to-- we've done a number of things. We're trying to look at how we can structure, I mean, a part of the hospital to handle, specifically, sexual violence and issues that go with it, in a way that can then be looked at as center of excellence. Now, if with the same zeal and determination PHR can come in and help me work with the universities alongside-- I mean, towards achieving this kind of vision, I think that will be very, very useful to me. Follow-up provided by PHR was described as helpful, and that having PHR assist in such efforts to standardize the pediatric training in medical schools could be helpful given PHR's name and influence. Law enforcement sector We conducted interviews with several law enforcement officials of various ranks to learn about the changes in law enforcement practices that were implemented as a result of PHR training. The most significant change described among law enforcement personnel was the greater consistency in which a formal "chain of custody" document is being used by police officers. One officer showed the interviewer a blank chain of custody form and explained how she uses it to track who has access to the evidence. She felt that the documentation made it more difficult for individuals, even other officers, to "lose" or otherwise compromise the evidence. There have also been key changes in law enforcement officers' capabilities in collecting forensic evidence from crime scenes. A major change is that some officers learned from the PHR training that they themselves can conduct and collect some forensic data without the approval or supervision of a medical professional. As one officer said, "I can collect the buccal swabs." This is important because it allows some evidence to be collected immediately and decreases risk of it being lost or contaminated as time goes on for a case investigation. Individuals in the legal sector, such as prosecutors and magistrates, are in a good position to evaluate the effectiveness of law enforcement officers in collecting and preserving forensic evidence. There is general agreement that in the more urban areas,

	the chain of custody, and the quality of evidence more broadly has seen some improvements since the PHR training. However, the law enforcement sector is where participants described most mistakes are being made, often resulting in the loss of evidence. A laboratory technician familiar with the analysis of forensic evidence described the situation: > [The police are] the only ones who can submit a forensic case. So, they were complaining that sometimes they don't understand how they should manage such kind of samples, reason being that the government chemist does not go out to give information, or train them, or even be with them on the crime scene. When they always bring samples, we always complain, 'You have not wrapped this properly. You have not labeled these.' And then we have to send them back. Indeed, police officers did express frustration with the process of submitting forensic evidence and getting the results. The government laboratory is understaffed and has an excessive backlog of cases to process. One officer said that he could wait 6 - 12 months to hear back from the laboratory. However, the interviews suggest a more immediate challenge: police officers do not have a reliable way to transport evidence to the lab in a timely manner. This gets magnified in departments where officers are handling more than one sexual assault case. > If you have 2, 3, or 4 cases that are happening. Maybe you have had one case maybe today, the evidence has been collected, you are supposed to take them to the government chemist, then maybe after 2 days, you have another? It becomes costly. The limited ability to get evidence to the government lab is the result of human and material resource limitations. There are simply not enough officers to spare one to drive the material to Nairobi. Further, officers who do travel to submit the evidence are often doing so at their own expense. These resource limitations have direct and significant effects on the ability of law enforcement officials to effectively collect and store forensic evidence. First, there is a shortage of officers and further, there is a shortage of officers trained by PHR in collecting forensic evidence for sexual assault cases. Similar to the circumstances in many Kenyan medical facilities, many law enforcement officers described situations where four or five of their colleagues were trained by PHR, but after a period of transfers, they remain the sole trained person in the agency. They have described

this situation as “leakage” where trained officers are assigned to areas where gender-based violence is not a department priority, or are assigned to cases other than gender-based violence and in these situations, they “cannot use their PHR training.” The shortage of PHR-trained police officers typically means that police take longer to respond during investigations, often resulting in compromised evidence. As one officer described, “By the time [the police] rush the victim to the hospital, time has passed, evidence has been tampered with, some things have been moved.”

Law enforcement officers trained by PHR generally understood their vital role in the collection of evidence and they generally lamented the limitations posed by a lack of trained officers. Further, they recognized a lack of space to safely store the evidence. The challenges posed by a lack of space or the appropriate facilities for evidence storage poses major risks to the security and quality of forensic evidence in sexual assault cases. As one department leader explained,

> We don’t have enough officers who are trained in storage of evidence. So that you find when that it's really Tom, Dick, and Harry at the station. Whoever is at the station is the one who will take the evidence and store it. How we will store it, doesn’t care, as long as it's locked in that room, that’s it.

While police officers are often aware of the importance of properly collecting evidence, their efforts are often hampered by a lack of material resources, such as vehicles and evidence storage supplies. Individuals who are trained by PHR rely on their own discretionary efforts to implement best practices. Many officers trained by PHR have reported using their personal vehicle to transport victims at their own expense. However, many officers understand that without the evidence, the perpetrator's case will be dismissed. One officer trained by PHR described how he and other “committed officers” respond to such situations: “You can’t sit back and say, ‘...I don’t have the supplies, I am not going to take this case to court.’”

However, thoroughly processing a crime scene takes time and effort away from other police activities, which can prompt priority conflicts within the department. PHR-trained officers acknowledge that gender-based violence cases are urgent and recognize the importance of taking a survivor to the hospital in fewer than 72 hours and that delays can hamper the effectiveness of prophylactic measures. However, their bosses ask, “Why are you handling these cases more often? Why are you spending so much time on these cases?” Interviewees described that these issues make it difficult to properly process cases because their supervisors are

	displeased with the amount of time and resources and officer spends on investigating these cases. This situation is often exacerbated by law enforcement leadership who "do not embrace the idea [of gender-based violence.]" This finding highlights the need for more members of law enforcement leadership to be trained by, or in communication with, the PHR program. Both medical and legal professionals also cited "unenlightened" law enforcement officers as an obstacle. These officers are typically not trained in the specificities of sexual assault, but they do not think that these cases warrant special attention or investigation, as compared to other types of crime. This causes difficulties for trained officers who attempt to implement best practices. Changes in law enforcement practices were reflected in law enforcement officers' descriptions of what happened in communities following their training by PHR. Interviewees from all sectors often suggested that successful evidence collection begets more prosecutions, which can increase the trust and willingness that other survivors have in coming forward after an attack. However, this is a double-edged sword. One officer said of his local community, "… They view you as a threat within their community. They view you as collecting more tangible evidence so that you can build a very concrete case." PHR-trained law enforcement officers described making strides in incorporating local chiefs and village elders into sexual assault response and evidence collection. Officers recognize that elders and chiefs are often the first people to arrive at a crime scene and are often the first people to which survivors and their families turn, and thus, have the greatest influence on preserving the integrity of evidence. As a result of PHR-trained law enforcement officers working with local community leaders, law enforcement officers describe that some chiefs have been very cooperative and have worked to disseminate information on the Kenyan "Sexual Offenses Act" and how individuals should protect elements of clothing after an attack. However, in other villages, law enforcement officers observed that these elders are resistant to such efforts because they fear it undermines their authority in the village. Further, village elders often profit from settling conflicts. For example, one officer described a situation where the village elder would receive part of a perpetrator's restitution to the victim's family, usually in the form of livestock. However, as police officers and other professionals have observed, reconciling assault cases out of court does very little to serve the victim. Legal sector Prosecutors, magistrates and other legal professionals described their behavioral changes, and their corresponding

successes and challenges utilizing forensic evidence in court. PHR-trained legal professionals reported comprehension and use of the evidence collected by medical and law enforcement professionals.

The PHR training was described as being helpful to court officials in understanding and changing the time and logistical constraints that they were previously placing on medical professionals. Some court administrations have modified the hearing schedules to better accommodate medical officials following the PHR training. Medical witnesses are required to testify in sexual assault cases, but the daily logistics of the court often result in changes or delays in hearing times, which keeps the medical professionals at court instead of at their facilities. To ease the court's demand on physicians, and to develop more effective relationships with the other sectors, some courts have given a "standing order" to hear sexual assault and defilement cases first thing in the morning. Not all magistrates and courts are willing to prioritize sexual assault and defilement cases on their docket, but in courts where it does happen, prosecutors have found less dismissed cases, less compromised evidence, and more successful prosecutions.

Another change in court proceedings is how the PRC form is used by prosecutors and magistrates. In court, prosecutors have found that information collected in Part B (psycho-social) of the PRC is extremely helpful in demonstrating harm and long-term effects suffered by the victim. This information is useful to the prosecution in demonstrating short and long-term psychological effects of their assault. This helps prosecutors demonstrate the severity of the crime and advocate for longer sentences. These changes also reflect prosecutors' perceptions of improvement in the quality of forensic evidence that they receive. Prosecutors said that better training for police and a new willingness to be advised by the courts on evidence collection has improved both the quality of forensic evidence and the relationships between police and the courts. We discuss this collaboration further in the Results section regarding "Efficiency."

Legal professionals still face significant challenges. The largest evidence-related issue for prosecutors is evidence that is damaged during storage. As described earlier, police stations have a dearth of secure, climate-proof evidence storage areas. One legal professional explained how "[Police] don't have enough storage, they don't have enough staff, enough trained staff. You'll find that in the process of them taking the evidence and storing it, it gets lost." Prosecutors and magistrates both have acknowledged the keenness with which defense attorneys work to have evidence disqualified and improper storage is "low-hanging fruit" grounds for dismissal. This is the largest obstacle for prosecutors. They appreciate the improved

quality of the PRC documentation, but it is often undermined by other compromised evidence.

While there was the behavioral change among some PHR-trained legal professionals to prioritize the day's docket, it was described as not doing much to shorten the time between the commission of a crime and its judicial outcome. Prosecutors expressed frustration with the way that sexual assault and defilement cases can be compromised by bribing investigating officers, providing gifts to the victim's family, and threatening the victims. Court officials felt that these risks are more likely when the time between the crime and the plea is too long. As one prosecutor lamented, "Before the investigations are done, it can take close to two years. So, most of the times this person just gives up on the case." This has been addressed by court officials as well - as a result of connecting with other stake holders at PHR training. Court officials are working toward shortening the length of time between an arrest of the perpetrator and a plea by fast-tracking these cases to trial. Of course, this also requires evidence analysis of sexual assault and defilement cases to be prioritized by the government laboratory, which has also been negotiated by magistrates and laboratory leadership.

Legal professionals thought it would be helpful to receive training on how to prepare victims, especially minors, to testify. One legal professional explained how "So often they get confused during testimony and contradict themselves and then the defense picks up on that." Legal officials understand the potential trauma experienced by survivors in a court setting. They can feel intimidated, demeaned, and be made to feel responsible for their own victimization. In some courts, victims give testimony out of view of the accused or in the magistrate's chambers. However, young victims' testimony can be used to discredit their grievances.

DRC

In the earlier stages of the program in DRC, interviewees described changes in occupational practices that were attributed by participants to the PHR training. Below, we describe effectiveness domain results by medical, law enforcement, and legal sectors.

Medical sector

Following the training, clinicians generally reported changes in their examination documentation practices, their use of supplies provided by the PHR program, and in their referral practices. With regard to changes in documentation practices, some clinicians described implementing the use of the forensic certificate following training, describing how using the certificate produced more thorough medical examinations that resulted in more thorough

	documentation and the collection of more medical evidence in sexual assault cases. Some clinicians described moving away from documentation of whether the hymen was perforated and more into a thorough, head-to-toe examination following the PHR training. Clinicians reported changing their language in documentation, removing conclusive statements from documents (e.g. "there was rape") and using more objective language (e.g. "compatible with sexual violence"). One clinician also reported implementing the use of post-exposure prophylaxis in her rural healthcare facility following the training. Several clinicians reported implementing the use of forensic photography following the training. Clinicians described how before the training, their idea of forensic photography was similar to taking photographs at a wedding, but now they take photographs that document the location and size of lesions (using a ruler) on the person, and photographs that document the identity of the survivor (using the survivor's face). One clinician described how her use of forensic photography validated a claim brought against her medical documentation that appeared in court, where the defense claimed that the medical record documentation pertained to another individual (and not the survivor whose case was before the court). The court was able to validate the clinician's medical documentation using the forensic photographs that appeared before the court. This is one example of how forensic photography is being used to validate the identity of the survivor relative to the medical documentation produced. Further, this example shows how forensic photography is being perceived as relevant and useful to medical investigations following the PHR training. As it regards supplies distributed by PHR, clinicians reported using cameras that were provided by PHR to take forensic photographs. Clinicians reported using memory cards for forensic photographs in case the camera is lost, but it remains unclear on how forensic photograph data is being stored and whether there are secure storage protocols in place. Several clinicians reported receiving a pediatric speculum from PHR, which in several cases was described as the first pediatric speculum that has been available for use in their health unit following the training. One clinician described how The pediatric speculum helps a lot when it comes to examining sexual violence cases of babies, children, because we receive children very often. And last time, we received a child that was four years of age, who was raped, and using this speculum is good for this child who doesn't have a big vagina. Using the adult speculum could create other lesions, but this small speculum is good because we just …introduce it in the vagina of the child to check if there are other

	lesions, and it doesn't harm her…That was the first pediatric speculum we received at the hospital. Clinicians described referencing the curriculum companion during medical examinations, and some claim that having the curriculum companion available has resulted in their conducting more thorough examinations. Clinicians reported using materials that were included in backpacks distributed following training, including: medical lexicon booklets, flashlights, gloves, disinfectant, markers for kids to draw, and curtains. The flashlights were often described as the most used supply, however there were complaints that the solar-powered flashlights stopped working or broke over time. The provision of curtains for survivor exams was described as being helpful. Clinicians described that with the curtains, they were no longer asking survivors to undress prior to an exam, and that the use of curtains increased survivor comfort during the exam. One clinician reported using a voice recorder that was provided by PHR in order to record survivor narratives regarding the sexual assault, but it is unclear whether other clinicians have been provided a recorder. It is also unclear how voice recording data is being securely stored. One major change in clinician practices regarding sexual assault victims was the decision, following training, to personally conduct the forensic medical examination of a survivor instead of referring the survivor to another experienced or more senior clinician. As such, more clinicians are conducting forensic examinations on survivors following training. Clinicians also reported referring survivors for psychological counseling following examinations, which they were not doing before the PHR training. Clinicians reported more client-centered interactions with survivors, including implementing methods to better respect the confidentiality of the patient (particularly within the healthcare facility) following training. Clinicians described the PHR training as practical, technical, and applicable to their practice. Clinicians described how in comparison to other trainings, the PHR training truly focuses on collecting evidence and provides insight into forensic medicine in a way that they do not receive from other trainings or from previous medical training (in medical school). As on clinician explained: I had a forensic course at university. It was such a useless course…When I was asked to come to the training here…of what I learned I said, 'Well, this is forensic medicine.' Because the training is so technical, clinicians described the desire for additional technical assistance immediately following training, where a PHR-trainer or technical assistance provider could observe/work with the clinician as the clinician documented evidence on new cases. Clinicians also described the desire for a

	longer training, which generally included the desire for a follow-up period of direct observation/technical assistance where the clinician could receive feedback during a real forensic medical examination of a sexual assault survivor. Finally, one clinician said that due to the nature of sexual assaults in Eastern DRC, particularly in rural healthcare facilities where emergent cases can be difficult to refer, it would be helpful to have trainings on fistula repair and laparotomy. Law enforcement sector Changes in the practices of law enforcement officers were described amongst participants themselves, but were also saliently observed by members of the medical and legal sectors. This latter observation highlights the leveraging (and sometimes problematic) role of the police in sexual assault investigations in the DRC. Law enforcement participants reported that the training assisted them with both the acquisition of new knowledge and guidance in practices concerning the collection, storage, and transfer of evidence – all aspects of sexual assault investigations that if conducted poorly, can be challenged by the defense. Several officers described collecting evidence incorrectly prior to the interview, including conducting poor interviews with survivors and not adequately storing forensic evidence that would be collected for the court. One magistrate commented on changes he observed in law enforcement participants following the PHR training, describing how the documentation provided by law enforcement is more precise now. It doesn't need to be too long to be precise. Now it can be short, but it is consistent. It has the precision about time, a place, but also has some elements in case they had some evidence to reinforce the report that puts the perpetrator in front of what happened. The training was described as helping police officers think about the body of the survivor as a crime scene, which produced more evidence collected from survivors (e.g. underpants that would be placed in a sealed envelope for court examination, or forensic photographs of survivors or crime scenes). In addition, police officers reported to begin showing up at the crime scene (where the assault took place) following receipt of a survivor's report, and collecting evidence from crime scenes (sketches, forensic photographs, empty alcohol bottles to validate the survivor's narrative, etc.) following training. One police officer described how her visit to a crime scene affected an investigation: The case that I have in mind is the case of a girl. She was selling in a small shop in [redacted]. This girl had two customers and these people were taking beer in the shop. It was late at night when the girl asked these

> two persons to leave. One of them said, 'Okay, you can go,' because they lived in the same compound. The other one remained. As it was late already, the lady took her mattress and laid it on chairs where she had to spend the night. The men started fighting against her because she didn't consent. She didn't consent, so he succeeded in raping her. That night, as she was screaming, the people who were doing patrol arrested the man. And the third morning we arrived there with all the necessary equipment that PHR gave us. So, we took the clothes because they were torn. We took the chairs, but also different things we found on the place of crime. This is something we couldn't do before, as he was arrested already so the investigators would be the patrollers. So, this man is brought in prison. He was put to court with all the elements that we found, we put on an envelope we sent to the court. He's spending his time in prison.

As it regards supplies provided by PHR, the camera was reported as being useful for forensic photography, but officers described that cameras run the risk of getting lost or stolen. One police officer was using a digital point and shoot camera that he personally purchased, but it was broken upon examination at the time of the evaluation interview. Police report that the solar powered flashlight has been particularly helpful, especially because there is no need to purchase new batteries. Police also reported using a meter provided by PHR that is being used to encircle the perimeter of crime scenes during investigations. In addition, police report using tape provided by PHR to label evidence collected at crime scenes.

As it regards interaction with the survivor, police noted that the PHR training orientated them to the forensic certificate, and that this orientation was helpful in how they understood forensic evidence of sexual assault. There is widespread attribution of the medical certificate to PHR. One law enforcement officer described the history of the medical certificate as it pertains to the introduction of the PHR program back in

> 2012 and it started here in South Kivu. I was not here at the time, but I was called. We attended a meeting where what we noticed was that the medical body and us, we never had to understand each other. First, because doctors wrote things we didn't understand. Second because their handwriting, they were writing like hieroglyphs. That was difficult for us to decode, uncode…Here in Bukavu, the solution for it was asking each body, "What do you need?" … So, the consequence was to have a document, the document which

	addresses the needs of every sector of actors. So, the judges when having the forensic certificate could find that it shed light on what they wanted to know, doctors communicate in a better way, police officers, and so on. So, this document was necessary because there are places where it was still kinds of dark zones and needed to be explained, they attached to it a lexicon. So, if you find difficulties, you go to the lexicon to see what it meant. So, we found that this document was very useful for us in South Kivu and North Kivu, we brought it to Kinshasa in the office of Madame Mabunda, who is the head of state Councilor, or in charge of sexual violence, for it to be standardized. Some police officers reported changing their listening techniques in collecting the narrative from the survivor, and some described changing their referral behavior to physicians (e.g. no longer asking physicians to determine the age of the victim). Finally, law enforcement officers reported making new referrals to psychologists following the PHR training. Police reported receiving training from Europol, UNDP, and the ABA on issues related to sexual violence. These other trainings were described as providing some information on how to collect evidence in sexual assault cases, but they were described as not being as specific as PHR's training. One police officer claimed that the PHR training is the most technical he has received to date as it concerns evidence collection in sexual assault cases. Police described the PHR training as being unique in its focus on techniques associated with the collection of forensic evidence. Law enforcement officer interviewees described that it would be useful to have a technical assistance period immediately following trainings where a technical assistance provider could enter the field with officers as they are conducting crime scene and/or case investigations. Police officers said that it would be helpful to have hands-on technical support from a law enforcement expert from PHR. There was the repeated comment that three days of training without this applied technical assistance portion was too short and risked law enforcement officers misapplying the investigation techniques acquired during training. **Legal sector** Changes regarding effectiveness in the legal sector were focused less on the technical collection of evidence and more on processes, procedures, and approaches toward sexual assault cases. However, the exposure to forensic medicine and aspects of the exam were considered useful for understanding the medical documentation that arrives in court. Individuals in the legal sector, particularly

	magistrates, explained how the PHR training introduced them to concepts of forensic medicine as well as the forensic certificate. One magistrate explained how > Before the training of PHR, we didn't have notions on forensic medicine at all…they gave us knowledge on how to collect evidence, how to store it…they didn't only give us techniques about collecting and storing sexual violence evidence but evidence for all kinds of crimes. To illustrate what I say, let me tell you that PHR gave us kits, and we had the gloves, rulers, and other things…There was a military who was shot at the airport. I didn't wait for a forensic doctor to come or the scientific police to come. I went there. As a magistrate, our practice, that changed. Whereas before, I would have touched the body, the corpse, with my fingers, but now I have to put gloves to turn the body. I could take my ruler to measure the diameter of the bullet. I could do these things. Legal sector participants described how as a result of the implementation of the forensic certificate, magistrates are now seeing less ambiguity within cases of sexual assault that arrive in court. Magistrates claim that they are seeing changes in practices concerning the collection and storage of evidence from physicians and trained law enforcement officers following the PHR training. As a result of the PHR training, some magistrates claim that now, in sexual assault cases, they are taking the approach of matching the narrative of the victim with the proof and evidence in the case, and then providing an interpretation that is informed by their increased comprehension of medical language attributed to the PHR training. Individuals in the legal sector were especially focused on the informational handouts provided by PHR, such as the curriculum companion and medical lexicon. Magistrates reported keeping lexicons and curriculum companions in their offices, and even referencing these materials in court during sexual assault case hearings. Magistrates described that prior to the PHR training, it was difficult to understand some of the terminology included in the medical documentation of sexual assault survivors provided by physicians. After training, they better understand the medical documentation that is arriving for sexual assault cases. Some individuals in the legal sector claimed that the PHR training changed the way in which they approached the survivor, and magistrates described changing the way in which they ask questions of the survivor during court hearings. As a result of PHR training, magistrates described changing their requests of physicians – instead of asking whether there has

	been a rape, they are now making different requests, such as whether there was any indication of violence. The PHR training was described as useful to PHR participants in coming to understand that it is not the responsibility of the physician conducting the medical exam to make a determination of rape. In the legal sector in particular, the focus of the PHR training on the collection of forensic evidence was described as being useful beyond sexual assault cases. Some magistrates reported applying lessons learned regarding the collection of forensic evidence to other cases not related to sexual assault in the DRC. As several PHR training participants were involved in investigations related to mass crimes or international criminal investigations that may not involve sexual assault, they reported applying lessons surrounding the collection of forensic evidence to these cases. For example, the collection of severed digits or applying latex gloves prior to handling a dead body at a crime scene were described as additional practices implemented for such cases following the PHR training. One lawyer described how now when she conducts investigations associated with mass crimes, she probes for additional elements of evidence and forensic photography that can be used in the investigations of those crimes. Individuals from the legal sector reported receiving sexual assault related trainings from the UNDP, ABA, and ACF. One forensic training program was described as not being as elaborate as PHR's, and in comparison, participants who attended both were impressed by the kits distributed by PHR. Individuals in the legal sector claimed that the PHR training was unique in its focus on forensic evidence. PHR trainees were also described as having more qualifications and experience in legal medicine in comparison to other organizations that provide training. In comparison to the standard legal education received with the DRC, the PHR training was described as providing additional information concerning conflict zones, medical forensic examination, technical aspects of forensic evidence in sexual assault cases, and its multisectoral approach. As it concerns training, there was the general request for more legal training from foreign entities. Individuals in the legal sector were interested in learning about how individuals in other countries, including the US and Europe, handle various types of sexual assault crimes in their jurisdictions. There was a desire for longer trainings, and more time spent with experts. From their unique viewpoint, magistrates generally focused on the need for more police to receive training. It was described that sexual assault cases varied dramatically based on whether the police officers involved had been trained or not. In particular, legal sector

participants referenced the need for all members of the "scientific police" to receive training.

Advanced trainings

In the latter stages of the program in the DRC, advanced trainings had been implemented and were paid particular attention in the evaluation. The objective of the advanced trainings conducted in the DRC was to impart the practice and techniques of forensic photography in crime scene investigations and in documenting the personal injuries of survivors of sexual violence. Participants in this training were primarily law enforcement officers, although many medical professionals also attended. DRC advanced training interviewees described their perceptions of PHR's advanced forensic photography training and explained how they are implementing the training's curriculum into their professional practice.

When asked directly about how they are using the knowledge they learned from advanced training sessions, most interviewees explained that forensic photography was now standard practice among police officers and some medical professionals. Photographs are being taken in various types of cases as a matter of standard practice and not just in cases where photography is specifically ordered by their superiors or just those that involve sexual or gender-based violence. It appears that greater photographic evidence collection across different types of cases is occurring.

One officer provided the following quote, which represents participants' general understanding of how forensic photography is different from less systematic modes of photography:

> When we learn how to take photos, what we call forensic photos, they are different from photos that people take for their leisure to put on social media. For these pictures, we have methods, we have material, and we have principles to follow. There are other things which appear on the picture which don't appear on the normal pictures. Like the further view, nearer view, millimeter tests.

Interviewees explained how the photographs improve the validity and the professionalism of their investigations. They, especially police officers, understood how properly collected forensic photographs can expand the scope of an investigation and produce a more comprehensive narrative about how and when a particular assault occurred, and provide insight that might lead to the identification of a perpetrator. Interviewees explained how the narratives that are deduced from photographs, corroborated by witness and survivor testimonies and the forensic certificate, can provide much more reliable information about the incident than the

more commonly used indicator: a survivor's broken or intact hymen. One participant explained:

> So, it is easy to do a link between the person, the wound, and the date when this person was wounded. Then it's easy to say this wound happened that time at that place and we could think of the weapon which was used for the wound, and this makes the difference. We did not do this before. The case would be lost.

Interviewees described specific situations where, by virtue of judicial bureaucracy, several months had passed after an alleged assault and when the case went to trial. In cases such as these, forensic photography was perceived to be particularly important. The wounds on a survivor's body would have already healed, and the bruising, swelling, and other indications of physical trauma would be gone. The photographs that are taken by the medical official, in conjunction with photos of the crime scene taken by investigative officers, demonstrate to the judge that the injuries were serious and were the result of an attack. According to one magistrate, seriousness of injury is an important consideration for sentencing or determining reparations. One police officer gave the following account of such an instance:

> I'm going to give a case that I have investigated personally. There is a woman who was aggressed by her perpetrator, and this perpetrator wounded the lady on her leg. She came to us, I photographed the wound. I sent the lady to the hospital for her to be taken care. She was taken care by the doctor, and months went on. When she came back, we pursued the case. But the wound was now a scar. And the doctor who documented wrote that there was a wound that healed on place X, but he didn't take the photograph of the wound, he just healed the wound and he wrote on her certificate that she had the wound that healed on X spot. When we brought the case to justice, I showed the photograph that I had, and this photograph showed consistency with what the doctor wrote, what the doctor described about the wound. They could see the description of the doctor and compare it with the photographs we had, and they said it was consistent. It helped the court for sentencing.

It should be noted in the above account that PHR does not train the police to obtain photographic evidence of wounds.

After attending the advanced photography training, participants recognized the importance of using forensic

	photography as a matter of standard practice as opposed to applying it to certain cases. Participants said that their superiors made clear the expectation, through department briefings and other formal communication, that photographic evidence must be collected in all cases in order for a file to be complete. Before, photographs would be collected on a case-by-case basis or perhaps only when specifically ordered to do so by their superiors. This suggests that officers were not consistently using cameras to document crime scenes or evidence. While law enforcement officers are not encouraged to obtain photographic evidence of wounds, participants described it nonetheless. One police official indicated that, because of cases like the one described above, to overlook a wound or to fail to photographically capture all wounds and injuries would be considered "a terrible mistake," and one that would involve punishment for the investigating officer. In case that I have given an instruction to the officer and he didn't follow, so he has to be punished. Because the principle is that when we receive a file, and we find that there are elements that are missing, we tell the person that elements are not there. For that person to look for the elements. Imagine you receive a person who has a wound, and I ask you to have the photograph-- I mean, send the case to the hospital so that we have evidence from there, and you don't do it. And the person comes back and the wound has become a scar. This is a terrible mistake. A direct outcome of the adoption of standard forensic photography protocols among medical practitioners is that they are more confident in their courtroom testimonies. As has been documented in previous evaluation reports, the relationships between expert medical witnesses and the courts were often addled with conflict and antagonism. Many physicians resented being called to testify because they felt that they themselves were on trial and that their medical expertise was constantly and derisively in question. One physician admitted that she had been threatened with jail by a defense attorney who had accused her of tampering with evidence because of how she completed the forensic certificate. After attending the forensic photography training, however, participants described feeling more immune to such attacks because they followed forensic principles and were sure that their testimonies indeed corroborated the photographs and the forensic certificate: they could not be contested. They also observed that the scope of their testimonies has expanded. Instead of solely reporting on whether or not the survivor's hymen was intact, typically considered a primary indicator of rape in DRC, the medical staff can make comments about wounds and injuries to the face and body. Further,

police officers can provide insight as to how the alleged crime occurred by bringing together survivor and witness statements in conjunction with the photos.

While the use of forensic photography in most investigations is becoming standardized in some areas, it is not evenly adopted. The expectation among law enforcement leadership about regularly taking forensic photos does not necessarily translate to these photos being taken in all geographical areas, which we discuss in a later section. The following section describes how advanced training participants have implemented important changes in how they interview and interact with survivors of sexual violence.

Consent and confidentiality

As part of the advanced photography training, participants described providing more survivor-centered services. It should be noted that the interviewees indicated that before the advanced training, issues such as consent and confidentiality were not necessarily important considerations when conducting a medical exam or photographing injuries. The training demonstrated to participants that good interviewing skills are key to the procurement of strong and court-admissible evidence. Interviewees stated that interviewing for the purposes of obtaining of consent and assuring confidentiality were definitive changes in their practice.

> But what the photograph training brought to me is mostly regarding how I can get permission to shoot pictures. I cannot take even the picture of her nails or whatever part of her body without her consent. And we have to fill the consent form. This was something I did not do before.

It should be noted in the above statement that PHR does not focus solely on female survivors, however the individual quoted above was using a female survivor reference. According to interview participants, sexual assault survivors are often reluctant to consent to photographs because they were unsure of how the photos would be used or who would see them. Survivors are concerned that the photos would be shared publicly and would become a cause of shame and stigma in their communities. When asked to explain how consent would be elicited through an interview, interviewees described that by showing compassion with traumatic experience one can establish trust with the survivor. One law enforcement official gave the specific example of learning to not “show astonishment”:

> I understood I got one of these big explanations about astonishment. They told us not to be astonished in front of the patient when the patient comes in for consultation. We should not show our astonishment

or ask questions like, "Why did this happen?" These kinds of questions asked to patients are kind of judgments that we are doing. But this takes time. I cannot be hurried. I have to change my process to take time.

In the advanced training, trainees were able to work out and practice potentially challenging scenarios with the use of standardized patients. Referring to standardized patients and other role-playing exercises of the training, interviewees said they found value in watching others interview a hypothetical sexual assault survivor. They would offer feedback to one another and pose various challenges they would likely face in their work, specifically on how to speak to pediatric patients. Some mentioned that they would convince a traumatized adult survivor that the photos were required for the pursuit of justice, which could be problematic when considering survivor consent.

Challenges in admitting forensic photographs into court

While describing their professional practice and the changes they have implemented, interviewees also revealed some of the challenges they encounter both while collecting forensic photos and while having them admitted into court as evidence. Some of the challenges are well-known human and material resource issues and others are newly uncovered procedural concerns.

The transfer in and out of law enforcement officers and medical personnel is frequent and ongoing. It was not uncommon for a respondent to say that while they were among several people in their work-unit to be trained by PHR, they were now the only PHR-trained individual left after a series of personnel transfers and relocations. Interviewees from law enforcement, health, and judicial sectors all recognized noticeable difference in skill levels of evidence collection between those who had been trained by PHR and the new, untrained individuals that are being transferred in as replacements for those who were transferred out. Members of the North and South Kivu networks both lamented the loss of PHR-trained individuals to other jurisdictions only to have to start “back at zero to sensitize the new people.” This often meant showing the new officers how to take forensic photos in an investigation, but more poignantly, convincing them that sexual assault is a serious crime that is worthy of prioritized investigative effort. For many officers, especially those transferred in from remote areas, sexual assault is not considered an important issue, even though it is a criminal act.

In addition to these known personnel issues, access to cameras is also an obstacle. Law enforcement officers, most of whom have been provided cameras and other photographic tools by

	PHR, suggested that there are not enough cameras to go around and that many officers do not take photographs and thus, investigative files are often incomplete. Specifically, police officers and other law enforcement professionals cited a shortage of cameras, color printers, and millimeter rulers: Yes of course, the camera must go with other tools. I talked about the printer before, and now I have to talk about GPS. We don't have them. We need to have also, is that a pencil? Yeah, we need to have the pencil. We don't have it. There millimeter test we have, but the [quantity] is small. It's not enough. We don't have any equipment for light. When it's dark, we need some light. We don't have the equipment for this, but we also don't-- we should have such specific lamp in our office for having the pictures. We don't have that as well. This lack of tools is juxtaposed with an institutional expectation that forensic photography is standard operating procedure, which encourages some officers to improvise. Some police officers admitted to using their smartphone cameras to take photographs when they did not have an institution-issued camera. However, they also recognized that this was an improper practice because it meant storing evidence on their personal property, which is a violation of confidentiality protocols. Further, any photos collected this way would generally not be allowed in court. A few officers felt as though they are "caught in the middle" of what their superiors expect of them and what they are able to accomplish in the field. Confounding this issue of limited human and material resources is the tendency for some magistrates in some jurisdictions to not accept photographs as evidence. The interviews revealed inconsistencies in accounts of how forensic photography is utilized in court proceedings. Specifically, magistrates explained how the photography is important for all case decisions regarding guilt, reparations, and sentencing, but police officers have also described situations where the judge or magistrate only wants to see forensic photos under certain circumstances, such as when there is counter-expertise testimony. In these cases, representatives of the court will come to the police station to view the photos on a computer or in-hard copy, as images of a survivor's genital area cannot be displayed in public. This scenario, however, appeared relatively uncommon, which suggests that many police officers and medical professionals are in possession of a large number of properly collected forensic photos on their computers and cameras that will never be reviewed in court. One police officer described the situation this way: PHR give us the tools to make pictures like camera, printer, but we have a problem to use it. Usually, we

	cannot bring them in the [forensic] report, but when there is some problem with the judgement, they can send some people to come and see the picture here in our laptop, our camera. But other places, they can take that picture and bring them to the court. For us, it's still a challenge. We have too much picture in our laptop, but they don't use it, they don't ask it. We don't use it, we don't know how to use it. It's there. It makes me think why we do this work if no one wants it. The discrepancy between law enforcement expectations that photographs are taken for every investigation and the reality that the courts only sometimes accept the photographs leaves some stakeholders wondering if it is worth the effort. This gap is similar to situations when physicians conduct a medical exam but the evidence is never collected by the police officers and is left in a storage locker at the medical facility. NUMBER OF POTENTIAL SURVIVORS REACHED In pre-training questionnaires, PHR trainees reported actively examining/interviewing/representing varying levels of sexual violence cases (by sector) in the 12 months preceding the questionnaire. Over the course of the three-year program, PHR reported reaching 1038 secondary beneficiaries, which includes the law enforcement (126), medical (621) legal (95), and other (192) sector participants. The median number of cases by sector reported in pre-training questionnaires was used as a proxy for the total number of cases reached across all program activities (spanning outside of training), and was 9 for the law enforcement sector, 10 for the medical sector, and 15 for the legal sector. Participants in year 1 would have reached 3 years' worth of cases, whereas participants reached in year 3 would have reached 1-years' worth of cases. Stratifying secondary beneficiaries by program spending estimates relative to individuals trained, a multiplier was developed to estimate the number of primary beneficiaries reached across these three sectors. The final number was 18,261.
Conclusions	As reflected in medical and legal records where services have been provided to survivors of sexual assault, PHR program exposure was associated with increases in medical and legal documentation quality that depend on multisectoral coordination. This coordination is dependent upon the implementation of best practices in complex local contexts, and participants from medical, legal, and law enforcement sectors provided specific examples of how PHR program activities changed their everyday occupational behaviors to achieve such outcomes in the DRC and Kenya. Participants also described

	programmatic efforts to support advocacy efforts that made documentation less cumbersome and more accessible for survivors in both countries. These changes are reflected the records/services provided to sexual assault survivors.

Table A1. Multiple-group interrupted time-series results derived from medical record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

	Documentation completeness outcomes				
Model terms	DOB documented	Date and time of incident documented	Number of perpetrators documented	Age of perpetrator documented	Location of incident recorded
Time	0.000435	-0.00116	-0.000435	-0.00116	-0.000435
(t for b1)	(0.13)	(-0.50)	(-0.13)	(-0.32)	(-0.58)
Cohort	0.0111	0.0511	0.00778	-0.113	0.0167
(t for b4)	(0.20)	(1.42)	(0.12)	(-1.34)	(1.15)
(Time)x(Cohort)	0.00145	-0.00565	0.00174	0.00261	-0.00145
(t for b5)	(0.38)	(-1.47)	(0.40)	(0.35)	(-0.71)
IP	-0.136	-0.145	-0.152	-0.133	-0.102
(t for b2)	(-0.80)	(-0.85)	(-0.74)	(-0.65)	(-0.53)
(Time)x(IP)	-0.0187	-0.00617	0.00410	0.00116	-0.00506
(t for b3)	(-0.87)	(-0.26)	(0.14)	(0.04)	(-0.18)
Treatment following intervention	0.134	0.231	0.178	0.157	-0.0258
(t for b6)	(0.78)	(1.25)	(0.83)	(0.61)	(-0.13)
Pre-post trend comparison	0.0114	0.0111	-0.0182	-0.0310	0.0216
(t for b7)	(0.51)	(0.46)	(-0.60)	(-1.00)	(0.77)
Constant	0.953***	0.986***	0.936***	0.930***	0.991***
(t for constant)	(21.55)	(35.71)	(19.67)	(18.91)	(91.36)

Abbreviations and symbols:

IP = Intervention period, DOB=Date of Birth, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table A2. Multiple-group interrupted time-series results derived from medical record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

			Documentation completeness outcomes		
Model terms	Chief complaint "incident" section filled out	Condom use documented	Documentation of whether reported to police	Known pregnancy documented	Pulse rate documented
Time	-4.27e-17	-0.00536	-0.000580	0.0143	0.00493
(t for b1)	(-0.00)	(-0.57)	(-0.17)	(1.52)	(1.08)
Cohort	-0.0778	0.0178	-0.0856	0.0767	-0.112
(t for b4)	(-1.29)	(0.15)	(-1.28)	(0.48)	(-0.83)
(Time)x(Cohort)	0.000725	0.0117	0.00623	-0.00304	-0.00594
(t for b5)	(0.22)	(1.14)	(1.40)	(-0.29)	(-0.65)
IP	-0.168	-0.0555	-0.249	-0.129	-0.147
(t for b2)	(-0.95)	(-0.26)	(-1.79)	(-0.61)	(-0.77)
(Time)x(IP)	-0.00183	-0.0221	0.00974	-0.0344	-0.0159
(t for b3)	(-0.07)	(-1.10)	(0.43)	(-1.26)	(-0.63)
Treatment following intervention	0.159	0.124	0.313*	0.0916	0.284
(t for b6)	(0.83)	(0.55)	(2.12)	(0.41)	(1.14)
Pre-post trend comparison	0.00843	0.00108	-0.0392	0.00854	-0.00322
(t for b7)	(0.30)	(0.05)	(-1.62)	(0.30)	(-0.10)
Constant	1	0.798***	0.951***	0.676***	0.916***
(t for constant)	(.)	(8.42)	(21.30)	(4.85)	(11.78)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table A3. Multiple-group interrupted time-series results derived from medical record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

			Documentation completeness outcomes		
Model terms	RR documented	Temperature documented	Documentation of whether survivor used toilet	Documentation of whether survivor left marks on perpetrator	Name and signature for examining officer
Time	0.00246	0.00246	0.00681	0.00232	0.00478
(t for b1)	(1.08)	(1.08)	(0.84)	(1.12)	(0.76)
Cohort	-0.216	-0.183	0.0322	-0.0233	0.103
(t for b4)	(-1.57)	(-1.44)	(0.21)	(-0.34)	(1.04)
(Time)x(Cohort)	-0.000580	-0.00217	0.00203	-0.00159	-0.00899
(t for b5)	(-0.06)	(-0.25)	(0.22)	(-0.35)	(-1.19)
IP	-0.123	-0.130	-0.218	-0.203	-0.139
(t for b2)	(-0.66)	(-0.69)	(-1.10)	(-0.97)	(-0.70)
(Time)x(IP)	-0.0189	-0.0135	-0.0215	0.00134	-0.0103
(t for b3)	(-0.79)	(-0.53)	(-0.83)	(0.05)	(-0.37)
Treatment following intervention	0.248	0.0890	0.115	0.234	0.233
(t for b6)	(1.01)	(0.38)	(0.55)	(1.04)	(1.09)
Pre-post trend comparison	-0.00675	0.0223	0.0145	-0.0186	0.0145
(t for b7)	(-0.23)	(0.79)	(0.54)	(-0.59)	(0.51)
Constant	0.958***	0.958***	0.797***	0.946***	0.903***
(t for constant)	(24.64)	(24.64)	(5.91)	(23.76)	(9.47)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table A4. Multiple-group interrupted time-series results derived from medical record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

	Documentation completeness outcomes			
Model terms	Date for examining officer's signature present	Name and signature for police officer present	Date for police officer's signature present	Documentation of informed consent
Time	0.00478	-0.00275	-0.00275	-1.97e-16
(t for b1)	(0.76)	(-1.10)	(-1.10)	(-0.00)
Cohort	0.103	0.116	0.116	-0.0567
(t for b4)	(1.04)	(1.40)	(1.40)	(-1.24)
(Time)x(Cohort)	-0.00899	-0.00159	-0.00159	0.0122
(t for b5)	(-1.19)	(-0.28)	(-0.28)	(1.79)
IP	-0.139	-0.00725	-0.00725	-0.0659
(t for b2)	(-0.70)	(-0.29)	(-0.29)	(-0.49)
(Time)x(IP)	-0.0103	0.00275	0.00275	0.0879**
(t for b3)	(-0.37)	(1.10)	(1.10)	(3.21)
Treatment following intervention	0.233	-0.0736	-0.0736	0.680*
(t for b6)	(1.09)	(-0.91)	(-0.91)	(2.30)
Pre-post trend comparison	0.0145	0.00526	0.00526	-0.135**
(t for b7)	(0.51)	(0.73)	(0.73)	(-3.01)
Constant	0.903***	0.0733	0.0733	1.92e-15
(t for constant)	(9.47)	(1.64)	(1.64)	(.)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table A5. Multiple-group interrupted time-series results derived from legal record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

	Documentation completeness outcomes				
Model terms	Date assault was reported documented	Number of assailants documented	Charge sheet present	Date of conviction present	Photograph of convict present
Time	0.00435	0.00225	-0.000725	-0.00188	0.00217
(t for b1)	(1.45)	(0.48)	(-0.76)	(-0.44)	(1.03)
Cohort	0.0778	0.0522	0.0267	0.188	0.0844
(t for b4)	(1.54)	(0.62)	(1.32)	(1.28)	(1.83)
(Time)x(Cohort)	-0.00435	-0.00152	-0.00232	-0.00757	-0.00493
(t for b5)	(-1.45)	(-0.29)	(-0.86)	(-0.79)	(-1.51)
IP	-0.0266	0.0483	-0.0393	0.00287	-0.0411
(t for b2)	(-1.10)	(0.81)	(-0.60)	(0.03)	(-1.05)
(Time)x(IP)	-0.00435	-0.00225	0.00256	-0.00544	-0.00217
(t for b3)	(-1.45)	(-0.48)	(0.45)	(-0.70)	(-1.03)
Treatment following intervention	0.0266	0.105	0.0528	0.174	0.0338
(t for b6)	(1.10)	(0.85)	(0.59)	(1.03)	(0.72)
Pre-post trend comparison	0.00435	-0.0314	0.000487	-0.00433	0.00493
(t for b7)	(1.45)	(-1.21)	(0.07)	(-0.28)	(1.51)
Constant	0.922***	0.898***	0.994***	0.112	-0.0111
(t for constant)	(18.25)	(12.98)	(123.82)	(1.88)	(-0.92)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table A6. Multiple-group interrupted time-series results derived from legal record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

	Documentation completeness outcomes				
Model terms	P3 form present	PRC form present	Forensic photography present	Report from government chemist present	Parental statement for child's age present
Time	-0.00570	0.00800	0.00196	-0.00820*	-0.00942
(t for b1)	(-1.02)	(1.25)	(0.91)	(-2.04)	(-0.76)
Cohort	0.101	0.0587	-0.0122	-0.0658	0.192
(t for b4)	(0.69)	(0.44)	(-0.73)	(-0.71)	(0.83)
(Time)x(Cohort)	-0.0113	-0.0131	-0.00196	0.00349	-0.0128
(t for b5)	(-1.17)	(-1.45)	(-0.91)	(0.58)	(-0.89)
IP	-0.227*	-0.304*	-0.0592	0.000362	-0.0573
(t for b2)	(-2.39)	(-2.48)	(-1.24)	(0.01)	(-0.45)
(Time)x(IP)	0.00936	-0.0135	-0.00196	0.00820*	0.0149
(t for b3)	(1.03)	(-1.14)	(-0.91)	(2.04)	(1.06)
Treatment following intervention	0.504***	0.369*	0.0592	-0.0179	0.151
(t for b6)	(3.61)	(2.29)	(1.24)	(-0.22)	(0.94)
Pre-post trend comparison	-0.0239	0.00163	0.00196	-0.00349	0.0110
(t for b7)	(-1.64)	(0.09)	(0.91)	(-0.58)	(0.61)
Constant	0.393***	0.222*	0.0122	0.196**	0.289
(t for constant)	(4.67)	(2.46)	(0.73)	(3.21)	(1.48)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

3.2 Relevance

Evaluation Criteria	Relevance
Evaluation Question 2	To what extent do the achieved results (project goals, 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	In both Kenya and the DRC, PHR programmatic activities promoted increased attention to, and resulted in increased justice sector accessibility for survivors of sexual assault, particularly minors. In both countries, participants described high caseloads of child sexual assault and extrajudicial settlements occurring for cases involving minors. The PHR program helped participants across sectors better respond to case needs across demographic (particularly age-range) spectra in implementing investigations that were more relevant to and centered on survivors' needs, thereby having implications for justice sector accessibility among survivors who received more tailored services. In Kenya, PHR responded to trainee feedback by developing and implementing an advanced pediatrics training (described in greater detail in the *Effectiveness* section of this impact analysis). Programmatic attention to child sexual assault survivors and developing a training aimed at this particular survivor-type is an example of the program increasing its relevance to the needs of survivors in real-time. Sensitization of individuals in the law enforcement sector helped to ensure that law enforcement personnel were equipped with knowledge regarding the importance of justice sector involvement in sexual assault cases as opposed to extrajudicial reconciliation with the perpetrator, survivor, and the survivor's family. Further, law enforcement personnel described providing increased survivor-centered service provision following their trainings, including designating specialized spaces for sexual assault survivors to report in police stations (which could result in the provision of a more detailed testimony). These changes correspondingly prompted law enforcement personnel to provide greater attention to sexual assault cases, with reports of increased follow-through in ensuring that survivors actually received a forensic medical exam whereas prior to the training, this type of follow-through was not occurring. In other words, gains made in the law enforcement sector increased health sector accessibility for survivors, in turn ensuring that a survivor had the strongest possible case (equipped with a medical forensic exam) when interfacing with the legal sector. Finally, PHR's investment in multisectoral networking and advocacy efforts resulted in changes in survivor-

	centered care, including individuals reaching out to and utilizing the network to troubleshoot issues in order to ensure that a survivor was not re-exposed to a perpetrator. In the DRC, increased attention to child-centered sexual assault investigations resulted in specific cases where the correct perpetrator was identified and another suspect ruled out, and where healthcare personnel reported using specific tools (e.g. the pediatric speculum) provided by PHR to produce improved documentation. Further, the program began training service providers who worked in more rural areas, where survivors were reported to have greater justice sector accessibility gaps. While multi-sector resources for survivors remains limited in the rural DRC, and while implementation of the forensic certificate will likely take more time to reach the interior, PHR-trained physicians described sentiments of gratitude among survivors who received more survivor-centered care from the physician following training. Finally, trainees in the DRC described changing investigative techniques in mass crime investigations, including implementing the collection of survivor narratives following the PHR training. Similar to Kenya, there was the perception across sectors that improvements in survivor-centered attention and treatment within law enforcement sector personnel following training resulted in greater justice sector accessibility for survivors.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	The evidence gathered to address the relevance evaluation criteria was qualitative in nature, derived from the experiences of healthcare, law enforcement, and legal sector trainees regarding specific cases where PHR initiatives affected the lives of women and girls during the course of program implementation. Interviewers asked respondents a series of questions regarding the relevance of PHR training to the specific needs of survivors of sexual violence. In other words, how does PHR training address, or fail to address, the specific needs of sexual assault victims in each country. Results are presented below by country (Kenya and DRC). *Kenya* In all of the Kenyan research sites, respondents indicated that defilement cases, or cases where the victim is a minor, make up the majority of their sexual violence cases. In some areas, trainees described how up to 85% of sexual violence cases involved minor girls and some medical facilities said they handle between 8 and 10 of such cases per week. In defilement cases, it is often the case that the perpetrator is a family member or someone else known to the

	victim. Trainees perceived these cases to be the most likely to end up being compromised or resolved out of court because the perpetrator is likely a relative or family friend and it is easier to convince the victim (and/ or her family) to not report the incident, or to accept some form of monetary compensation in exchange for withdrawing the case. Underlying many of the changes in professional protocol and changes in understanding the importance of forensic evidence in sexual violence case are shifts in the basic perceptions of survivors as being worthy of quick action, protection, and access to justice. Without proper evidence collection, many respondents acknowledged, the cases would be dismissed or thrown out and there would be no justice for the victim. Respondents speculated on the psychological harm it could bring about, and the perpetuation of a culture of impunity. When medical professionals described how they conducted forensic exams before attending the PHR training, they described how they conducted superficial exams and were loathe to testify in court because of the antagonistic treatment by defense attorneys. They had not necessarily made the connection between conducting a medical exam, providing strong testimony, and the accomplishment of justice for the survivor. After the PHR training, medical staff experienced changes in their perceptions of how their work contributes to justice more broadly and how to better prepare for cross-examinations in court. By working to collect admissible evidence and attending to the needs of the prosecution, medical professions demonstrate to their patients that they are deserving of justice and that sexual violence "is not a normal part of females lives." As one physician noted, If I do a mistake, I don't get good history, I don't do good examination, I don't do good laboratory aspect, we lose the case. In cases where the survivor is a minor and the perpetrator is a family member, the survivor and perpetrator often live in the same household or community. This was recognized by many respondents as an unmet need for survivors and a major threat to the accomplishment of justice. Police officers felt they often had no other options than to release the survivor into the same household as the perpetrator, which places her at risk for further assault and/or intimidation. Prosecutors encountered a similar challenge when the perpetrator was released while the case was pending and of course, he would be released to the same household or community in which the survivor was currently living. A prosecutor gave the following example to illustrate this issue: The father defiled the minor, and the father has been released on bond, so at the end of the day they met at

	home. This mother and the minor have been imprisoned by the family. They don't know where to go. They come to us, we are interested in securing a conviction, but nobody bothers where this woman and the child are going to go. Trainees did not have a clear idea as to how PHR could directly address this concern other than to help advocate on their behalf for victim-protection services. However, trainees described utilizing their PHR- supported networks to brainstorm solutions. A different prosecutor gave the following example: …there was the issue of witness protection, for example in incest cases, where it's a defilement case where father has defiled his daughter. We were trying to brainstorm on ways through which we can safeguard the interest of this complainant, since once this father has been released on bond, he'll just go back to the same home and the perpetrator and the survivor will meet. We were inviting magistrates to deny these perpetrators bond for purposes of sanity of the complainant. The problem of further interaction between perpetrators and victims is exacerbated by class differences, specifically when the victim comes from a poor family and the perpetrator has access to greater material resources. Respondents gave examples of cases in more remote areas where the perpetrator was a repeat offender, but one who escaped accountability because he was wealthy and was able to use his affluence to compromise cases or to avoid accountability all together. These cases were perceived to both deny the survivor a sense of justice and to promulgate a culture of impunity. One magistrate described this scenario: What will happen is that [the perpetrator] will go ahead and do the same to another family. Just because he knows that he is rich and just go to where he keeps his cows and then gets maybe five, four heads of cattle and give that to the families. You know there is nothing that will prevent him from doing this another time and another time. So, if we rely on the criminal justice system by convicting these people it's a way of deterring other members of public from doing that. And then once the person is convicted, let's say for fifteen years, once he gets out of jail, I don't think he will make the same mistake. But if you go to reconciliation or arbitration this never occurs. If it's a very rich man with a thousand heads of cattle, like he won't suffer anything. However, cases such as these were becoming rarer as police officers took these cases more seriously, collected evidence, and ensured that resolution did not take place outside of court. Police

	officers acknowledged the implications for the survivors of forcing the case to proceed, as one stated: "When there is just money or animals changing hands, it does not serve the justice for the victim, she has to continue seeing him every day like nothing happened." Sensitization to this issue among law enforcement trainees is thus one mechanism through which the PHR program is relevant to survivors accessing justice. PHR trainees described making changes within their occupational environments to reduce felt-stigma among survivors of sexual assault. In Kenyan communities, like communities everywhere, there exists a strong stigma against sexual assault survivors. Stereotypes and biases persist against survivors that suggest they are to blame for their own assault, or that survivors are contaminated or broken in the purview of other men and community members. One police officer described a situation where one survivor was shunned by her husband and banished from the household, him calling her a "soldier's wife" and she had to seek support from the perpetrator's family. Fear of stigma and fear of retaliation keep survivors from reporting the crime and seeking needed medical attention. Doctors acknowledged that crowded emergency rooms would cause sexual assault survivors to wait long periods of time, become discouraged, become frightened of being recognized by others, and ultimately leave before being examined. In the case of minors, police officers would often "drop-off" the minor at the hospital with the intention of coming back after they had attended to other business. During that time, the minor would leave the hospital or be taken away by a family member. Of course, this would result in a missed opportunity to collect evidence and in the perspective of medical professionals, to pursue justice. In contrast, this type of behavior was reduced among PHR-trained law enforcement personnel. In areas where medical facilities had specialized exam and interview rooms dedicated to forensic examinations and medical care for survivors of sexual assault, physicians and nurses were often able to prioritize these cases and allow the patient to been seen right away. The same is true for police stations. One police officer showed the interviewer a room that was refurbished with a locking door and a private entrance where they could conduct interviews in private and away from other people in the station. After PHR training, both medical and law enforcement professionals were sensitive to the stigma surrounding sexual assault victimization and the potential for lost evidence. These changes in occupational settings reflect more survivor-centered approaches implemented by trainees following the PHR training. Finally, the program's grounded programmatic evaluation strategy took into account participants' description of child sexual

assault survivor caseloads, developing the advanced pediatrics training described in the *Effectiveness* section of this impact analysis.

DRC

> "Everything that we receive from PHR, the last beneficiary is the survivor. When we learn how to work on them, how to listen to them, how to conduct examinations, collect evidence, send to the court, the court understanding all the whole process and then, there is prosecution of the perpetrator. All this is done for the benefit of the survivor."
>
> -*Physician, DRC*

Across sectors in the eastern DRC, individuals were able to provide examples of cases where PHR trainees used techniques gleaned from the PHR training to directly and relevantly assist survivors of sexual assault in pursuing justice. There were several accounts of individuals using investigative techniques learned from PHR trainings to correctly identify the perpetrator in a child sexual assault case. For example, one lawyer described how

> There is a case of a child, six years of age… there was a shoemaker who took an object. I think that he penetrated in the vagina of the child, not his penis. This thing was introduced up to inside the vagina of the child. The child was bleeding terribly. The child was brought to us. We took the child, and the child showed the person who was the rapist, and this was the shoemaker. And this person said, "I did nothing to the child. She is pointing me because she knows me." We took the child to HEAL Africa, and from the court with the child-- HEAL Africa after forensic examination, they found that the hymen was there, but the bleeding was so much. So, we didn't understand how the hymen was there, but the bleeding of the child-- we put a lot, a lot of nappies to arrest the bleeding, but the child continued bleeding, bleeding, bleeding…So the importance of the training was to bring the child to the doctors for investigation. Otherwise before, we would have just arrested the shoemaker thinking he raped the child... But now that we knew that the hymen was there, so we had to look for what made the child bleed. And we found that it was a needle, a needle which was introduced in the vagina of the child. We continued investigation until we found that a person who lived in the same house with the child introduced the needle in the child's vagina. So, this helped

	us not to condemn an innocent, who was the shoemaker, but find who was the real perpetrator of that. In Goma, individuals reported working with a large portion of child/minor cases. Some physicians reported that the majority of sexual assault cases they have worked with have been cases of minors. The provision of the pediatric speculum by PHR, in this context, is particularly relevant. Some of the child/minor sexual assault cases are described as being complicated by the fact that there is an appreciable subpopulation of these cases that come forward as a result of teenage pregnancies where the survivor has an amicable relationship with the father, but the mother (and in some cases the father) is underage. Training participants were able to use investigative techniques provided during training in order to resolve complicated cases involving children, such as children being sold by family members into sex work, or in cases where there was difficulty identifying the perpetrator of the sexual assault. One police officer who began showing up to crime scenes following the PHR training, described how he was able to collect evidence that validated a child survivor's testimony. Across sectors, individuals reported making attempts to better provide survivor-centered care. Following the PHR training, physicians reported conducting much more thorough exams for survivors who report first to the hospital, with the understanding that this examination could have implications for a survivor's case if it were to move forward in a legal manner. For survivors who arrive as a result of police referral, some physicians are just complying with the police request and not doing anything additional. This may be an area that could be improved, in service of the survivor, through police-physician communications or in client-centered care driven by physicians. Healthcare workers generally reported providing greater attention to the quality of patient care, including increased attention to respecting patients, patient confidentiality, physician-patient trust, obtaining patient consent, and in not displaying discrimination following PHR training. Across all sectors, there was greater attention to the psychological needs of survivors, both after an assault and during investigations. Physicians reported implementing more referrals to psychologists following the PHR training to ensure the wellbeing of the survivor. In one case of gang rape, through collaboration with the network, PHR trainees were able to get the survivor additional psychological support as the case was being processed. As it concerns attention to survivor safety, through the network there were additional efforts being made to place the survivor outside the location where the complaint was lodged in order to better insure the survivor's safety during an investigation.

	Individuals from the legal sector noted that *PHR-trained* police officers often treated the survivor differently following the PHR training. This includes the police going out of their way to establish safe spaces for the survivor, and better ensuring the dignity of the survivor (as mentioned in the interviews) throughout the course of an investigation. There were some areas that were identified that could be directly useful in better serving the needs of survivors. One physician noted that for pediatric trainings, it would be helpful if they could be helped with the acquisition of Ketamine, including trainings on the administration of Ketamine, for training participants to receive for conducting pediatric examinations. Further, one of the challenges described in accessing the legal sector is that survivors still have trouble finding lawyers to help them process their cases. Current challenges to victims' access to the legal system include victims' perceptions, including that: 1. feel the justice sector is exposing them, 2. they perceive there will be no reparation and 3. They are unsure of what will happen if the perpetrator does not go to jail. In the DRC, the PHR program began training more participants who provided services to sexual assault survivors from rural areas. On this note, PHR trainees from rural areas described a "beneficiary gap" to survivors in rural areas (this beneficiary gap is likely an artefact of the program's nascent reach into rural areas). Participants coming from rural areas (such as Minova) expressed feeling that these areas, and survivors living within them, are generally forgotten by outside groups in comparison to survivors residing in primarily urban municipalities such as Bukavu. Some physicians noted that the primary beneficiaries of the PHR training were survivors residing in Bukavu or urban municipalities in Eastern DRC, and that there was a major gap for rural survivors who cannot readily access healthcare facilities such as Panzi Hospital. There was a perceived correlation between sexual assault by armed groups and rural location of the survivor. Physicians noted that in sexual assaults with armed groups, there are more emergent cases and that healthcare facilities serving these areas need assistance with equipment and supply management. Bullet trauma, internal bleeding, and fistulas were some of the common issues identified in sexual assault survivors living in rural areas. Fistulas still have to be referred to Panzi hospital. It was acknowledged that due to resource limitations, many rural facilities are unable to provide certain types of examinations or to refer survivors to psychologists, even though suggestions to do so were made during the PHR training. In rural areas, there also tend to be many cases with foreign object insertion (e.g. wood, a gun), and sometimes survivors cannot get to Panzi Hospital in time to treat the resulting

	injuries. Physicians in rural areas felt that foreign object insertion during sexual assault was more frequent in rural areas, although they had less resources to adequately deal with these types of caseloads. Further, healthcare centers in rural areas need help resolving issues surround the referral of internal bleeding and fistula that require long (and painful) transport of the survivor to Bukavu. Finally, survivors in rural areas may still be asked to pay for photocopies of their medical certificate due to limited resources. However, one physician from a rural setting claimed that survivors have been coming back to thank him for his support following the PHR training, even if their cases do not progress. In rural areas, many women were described as not wanting to go to a hospital because this will be perceived as generation unwanted attention for a case that will go nowhere. There was a general desire for more multisectoral training throughout rural areas, including the towns and territories in North Kivu. Participants often reported utilizing investigative techniques provided during PHR trainings in mass crime investigations. As such, the PHR training has been relevant to victims of mass crimes. One military magistrate explained how in international criminal investigations, they are now collecting survivor narratives using techniques provided during the PHR training. In some cases of mass rape occurring in rural areas near Minova, PHR-trained physicians are triaging sexual assault survivors to healthcare facilities in Minova, Numbi, and Bolinga, with emergent cases being given priority. One legal sector participant said that it would be helpful to have technical assistance from PHR in conducting mass crimes investigations, and she was interested in whether doctors or psychologists could join the field teams to support mass crimes investigations. Legal sector participants described experiencing problems in dealing with cases of impunity that occurred prior to the ratification of the Rome Statute. Further, one magistrate noted that individuals in the legal sector in the DRC need refresher trainings on the Rome Statute because there are too many gaps in knowledge on the ground. One legal sector participant explained how My opinion is that when specific cases are clear and the Congolese laws can be applied, judges could use the Congolese law. But in case there is ambiguity that there is an infringement for which the Congolese law didn't foresee something, then we could use the Rome status because the country ratified it. And the status of Rome leaves open windows for things to change. So, I think it's not impossible when it comes that there are blockages regarding the national law to use the Rome status… The problem now is there are infringements

	which happen before the Rome status was ratified, and the advocacy that is made is to ask that the Rome status is applied even before the ratification. That is where the two opinions diverge. Some people say that it is necessary to create specialized mixture courts. Other people ask for a creation of an international court for DRC. Legal sector participants were interested in whether PHR could assist with helping to integrate the frameworks of consultation on issues concerning mass crimes and international justice. One legal sector participant was interested in whether PHR could collaborate with MONUSCO and the UNDP in order to better equip legal sector participants for mass crimes investigations. One lawyer described that one of the current problems occurring in mass crimes investigations is that the high per diem is an incentive for higher ranked individuals to travel to the scene of the crime, even though their lower-ranked subordinates may be better qualified to conduct the field investigations. As such, the higher-ranked individual who travels for the per diem conducts an inadequate investigation, and the case suffers for it.
Conclusions	The extent to which the PHR program's achieved results were relevant to the needs of women and girls (including all survivors of sexual assault) is evident in the program's unique attention to the provision of survivor-centered care by service providers across sectors in both countries, where increased programmatic attention was provided to child sexual assault cases, rural survivors and mass-crimes investigations. These programmatic results helped secondary beneficiaries (service providers) implement investigations that were more relevant to and centered on survivors' unique needs that varied according to the location in which secondary beneficiaries were operating, thereby improving justice sector accessibility among survivors of sexual assault.

3.3 Efficiency

Evaluation Criteria	Efficiency
Evaluation Question 3	To what extent was the project efficiently and cost-effectively implemented?
Response to the evaluation question with analysis of key findings by the evaluation team	The program aimed to accomplish a number of outputs that involve far more than knowledge acquisition and behavior change among secondary beneficiaries who provide services to survivors of sexual assault. A core activity of the program is training dissemination of best practices through training of trainer and mentoring models, that in the context of the program's results framework is intended to achieve knowledge acquisition and behavior change for a wider range of secondary program beneficiaries. Over the course of the project period, the program developed and tracked training-of-trainer and colleague mentoring models that resulted in the program reaching an exponential number of secondary beneficiaries (exceeding the secondary beneficiary target) that could not otherwise be reached through the direct training model. The gains in these efficiencies were validated by qualitative findings, but should be taken into account with the "dose" of knowledge dissemination associated with the quantitative reach associated with this particular activity. Beyond training, however, the program engaged in complex and sustained interactions with individual institutions across various settings, and managed to achieve institutional outcomes that reached far beyond the individual capacity building and knowledge dissemination activities on which this particular efficiency analysis is centered.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	PROGRAM SPENDING RELATIVE TO NUMBER OF INDIVIDUALS TRAINED In order to answer questions concerning program efficiency, we focused here on the number of individuals trained within the project period, and the number of new colleagues trained and mentored by PHR trainees. The second outcome (the number of new colleagues trained and mentored by PHR trainees) reflects the program's focus on developing trainer of trainer and mentoring capacity among secondary program beneficiaries. The program focused its efforts on numerous other activities that had institutional impacts on secondary beneficiaries (but which are less amenable to this cost efficiency analysis) during the program period. For example, data derived from program record monitoring spreadsheet includes: the completion of two patient pathway and service assessments at health centers; eight recommendation documents provided to health centers; two completed plans developed that detail how institutions will integrate forensic training material into curriculums, protocols, practices, and in-service and pre-service trainings; two completed and signed agreements between PHR and selected institutions

	concerning details of a joint plan; and four institutions reaching standardized benchmarks in accordance with PHR guidelines. Thus, the efficiency analysis works with crude estimates that are relevant to the core programmatic outputs that focus on knowledge acquisition and behavior change among secondary beneficiaries that does not reflect the entirety of the program's spending on all program activities, but that is intended to represent how the program implemented a core results-generating activity relative to its bi-annual spending. To reach its goal, the program targets service providers (secondary beneficiaries) to survivors of sexual assault. Over a 3-year program period, the program aimed to reach 550 secondary beneficiaries. In total, PHR directly trained 1,011 professionals from January 2016 to December 2018. While other funds were used to help amplify the number of trainees reached with UNTF funds, a highly conservative estimate of trainees directly trained over the 3-year program period with UNTF funding was 189. The number of new colleagues trained, community members reached, or individuals mentored by PHR trainees was 3,735. The overall amount billed by the program over 36 months was $975,000. Thus, the target ratio of secondary beneficiaries to be reached was $1,772.7 per secondary beneficiary. Through the program's emphasis on community outreach, colleague mentoring, and trainer of trainers, the actual ratio estimated was $261.04 per secondary beneficiary. While the number of individuals trained relative to program spending in a bi-annual period remained relatively constant (See Figure C1), the number of secondary beneficiaries reached through the program's focus on training of trainers, mentoring, and community outreach began generating more exponential gains near the halfway spending/program-period mark (See Figure C2). The curve occurring after the third 6-month project period represents gains in efficiency associated with the program's development and implementation of a training of trainer/colleague mentoring model. Through its sustainability and dissemination model, the program was able to exceed its intended number of beneficiaries reached at the end of 2nd year. This quantitative efficiency described in the ratio, however, does not reflect an even "dose" of what was received by secondary beneficiaries. QUALITATIVE EVIDENCE FROM SEMISTRUCTURED INTERVIEW DATA *Qualitative interview evidence from both Kenya and the DRC confirmed that PHR trainees and program participants (secondary beneficiaries) engaged in a range of community outreach, training, and colleague mentoring sessions. The "dose" of knowledge*

	dissemination and acquisition relative to core PHR trainings varied, however. In Kenya, PHR-trained physicians described using knowledge obtained through PHR training to train other medical colleagues through Continuing Medical Education (CME) sessions and/or during grand rounds (e.g., with OB/GYN residents). Some described practicing becoming trainers by participating as trainers in PHR trainings. Participants described training of trainer (ToT) sessions provided by PHR as useful in helping them organize and deliver their own trainings. ToT trainees described holding their own abbreviated training sessions that were typically limited to focused, 1-hour meetings with advanced medical students or colleagues. Sessions focused on pediatric issues including taking the survivor's narrative from a child, and rapport building with child sexual assault survivors. In less standard/unstructured occurrences of knowledge dissemination conducted by PHR trainees, on the job mentoring was described. In the law enforcement environment, this included PHR-trained police officers helping colleagues conduct their own investigations of sexual assaults. This involved accompanying other officers in the field to collect evidence/exhibits, by directly showing colleagues how to work with traumatized survivors, and by focusing on medical evidence collection and transfer. To describe concepts to colleagues, laminated curriculum companions and notes from previous PHR trainings were used to provide visuals/examples and to clarify concepts on a case-by-case basis. While police transfers are issues presumed to mitigate the impact effect of PHR's program, we found evidence of PHR-trained police officers who were transferred to a new post and who, following transfer, provided one-on-one mentoring to untrained colleagues (on a case-by-case basis) on best practices as untrained colleagues' sexual assault investigations moved forward. There were other forms of knowledge transfer described, including social workers training networks of survivors in the community (members of community-based organizations) to help navigate new survivors through the medico-legal web (or training survivors now working as volunteers to help navigate new cases and to increase case processing efficiency). In the DRC, secondary beneficiaries described conducting trainings, formal and informal, on topics of sexual violence and evidence collection. These trainings occurred in their local communities, as

	well as in neighboring countries, namely the Central African Republic (CAR). Few of the interviewees had organized or facilitated day-long (or longer) formalized trainings on their own, but they almost all participated in "continuing professional education" sessions in their home institutions. Others participated in a training event that was organized and financially supported by some other organization or government agency. The most common venue for secondary beneficiaries to organize a training on their own was at their home institutions. For instance, medical staff may conduct informal sensitizations of their colleagues in regularly-scheduled (often monthly) staff trainings. It is often the case that after any professional training, the individual receiving the training will share newly-acquired information and materials with their colleagues in one-to-two-hour informational sessions, depending on the hospital or facility. This was the case in institutions such as Panzi Hospital and Heal Africa. Beyond the trainings at their home institutions, secondary beneficiaries were often invited by another organization (such as MONUSCO or a missionary group) or a government agency (such as a unit within the military police) to deliver a presentation on some topic as part of a larger event. The trainer would address topics ranging from general public awareness of sexual violence to highly technical lessons on forensic photography for professionals. The trainer would provide a one-hour presentation on some topic and for the most part, would use PHR materials such as a PowerPoint presentation. Sometimes, if appropriate, the trainer would provide handouts for the attendees to take home with them for reference. However, this was only done when the sponsoring organization agreed to provide the photocopies. One trainer said he would offer to email electronic versions of the training materials to the attendees but questioned the efficacy of that approach because most of them did not have regular access to a computer. One ToT participant said that she has an easier time organizing "open-house" type events where logistics are less demanding. When training outside their own institutions, secondary beneficiaries were very keen on understanding who their audiences were before their scheduled training began. While they depended on curriculum and materials from PHR for their trainings, secondary beneficiaries recognized that their delivery would have to be tailored to their different audiences and to do so effectively, would require some reconnaissance.
Conclusions	Beyond programmatic spending associated with patient pathway and service assessments at health centers, the generation and delivery of recommendation documents provided to health centers, completed plans for institutions to integrate forensic training material into curriculums, protocols, practices, and in-service and

	pre-service trainings, and the generation of signed agreements between PHR and selected institutions concerning details of a joint plan, the program developed and implemented trainer-of-trainer and mentoring models that by the third spending period illustrated efficiency in the number of secondary beneficiaries reached. Qualitative evidence shows that while dose of the program's effect was attenuated within these numbers, various models of disseminating best practices occurred across sectors and countries. This particular efficiency analysis focused on building capacity and disseminating knowledge, and the program exhibited efficiencies by month 18 of program activities.

Table C1. Bi-annual program spending, persons trained, and the number of new colleagues trained and mentored by PHR trainees

	Cumulative			Within 6-month project periods		
Project Timeline (months)	Project funding billed	Persons trained	Number of new colleagues trained and mentored by PHR trainees*	Project funding billed	Persons trained	Number of new colleagues trained and mentored by PHR trainees
6	$81,408.00	32	10	$81,408	32	10
12	$217,536.00	43	63	$136,128	11	53
18	$406,752.00	97	274	$189,216	54	211
24	$565,951.00	112	969	$159,199	15	695
30	$762,953.00	155	2,630	$197,002	43	1,661
36	$975,000.00	189	3,735	$212,047	34	1,105

**Data derived from program record monitoring spreadsheets*

Figure C1. Program spending and the number of secondary beneficiaries directly trained by PHR

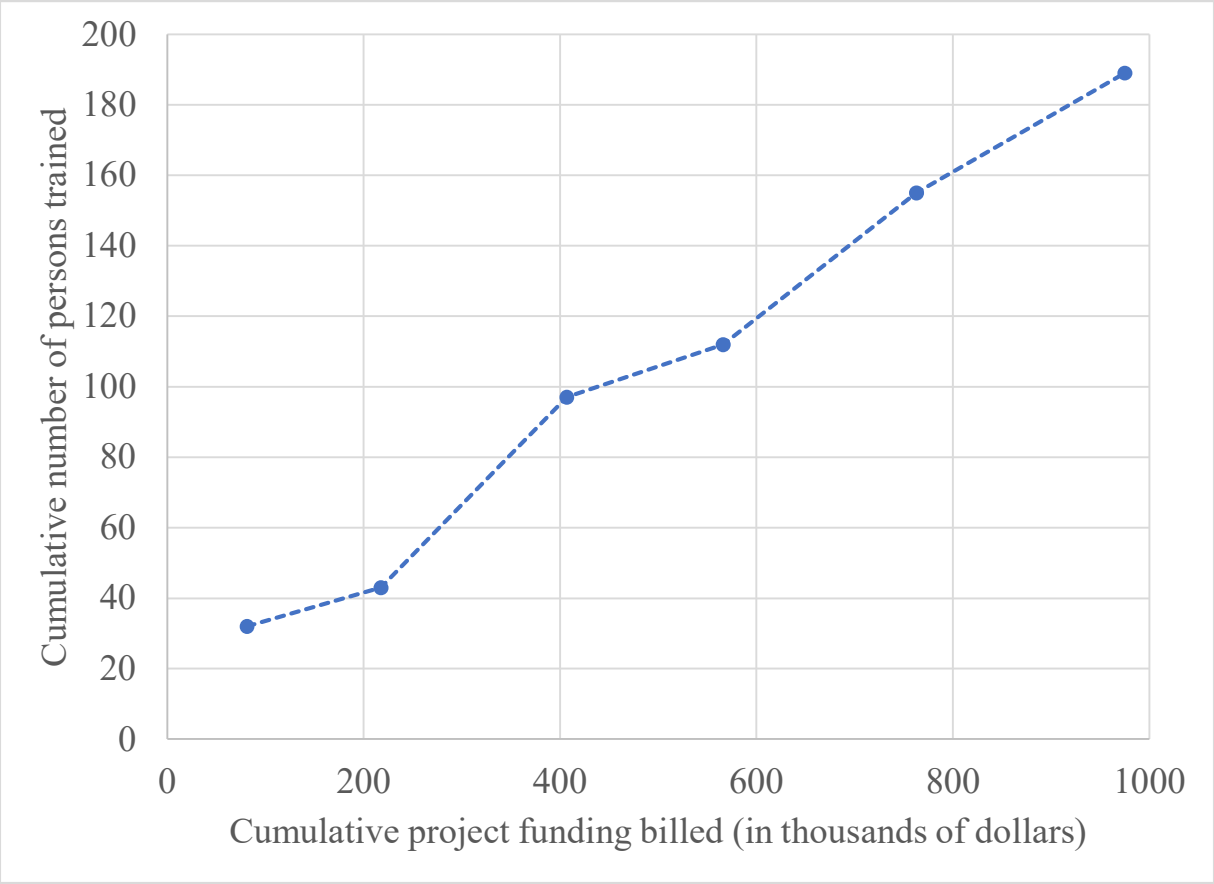
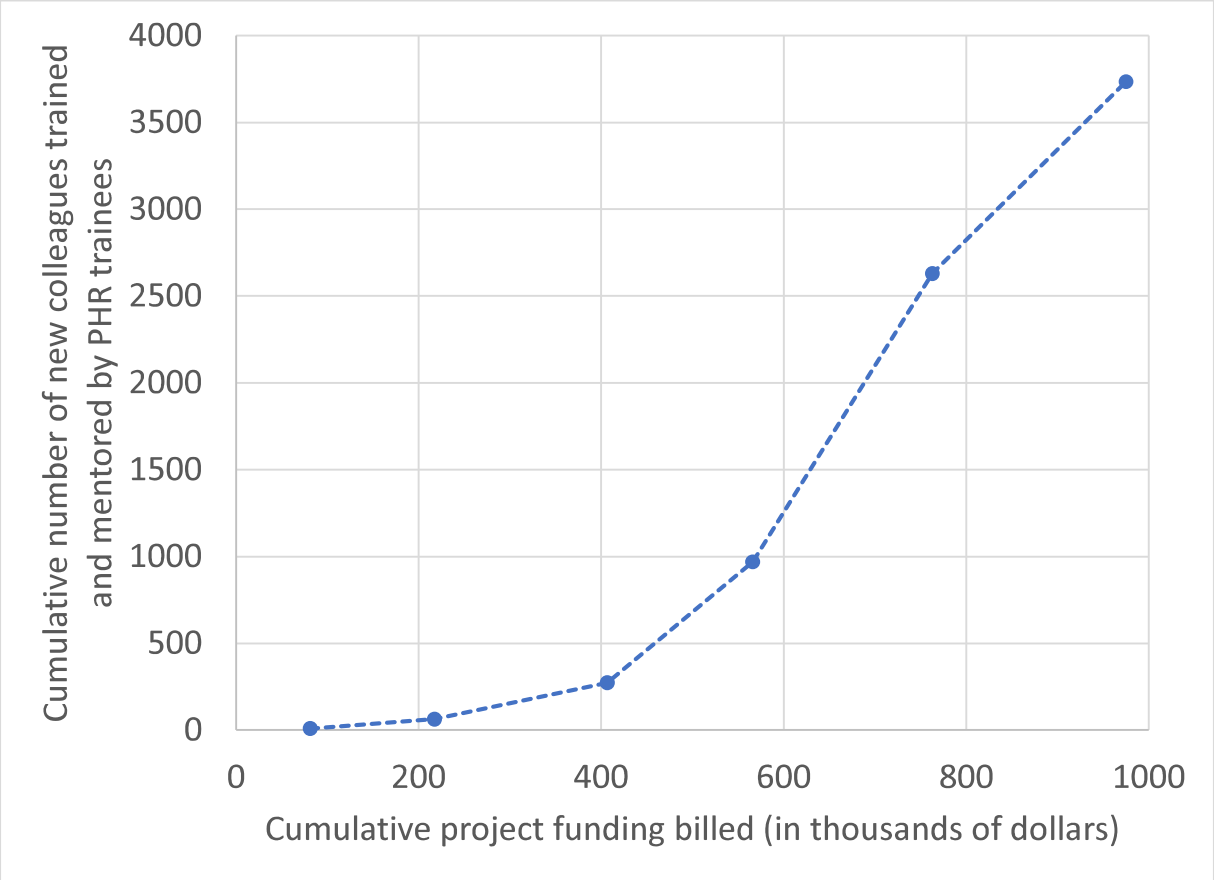


Figure C2. Program spending and the number of new colleagues trained and mentored by PHR trainees



3.4 Sustainability

Evaluation Criteria	Sustainability
Evaluation Question 4	To what extent will the achieved results, especially any positive changes in the lives of women and girls (project goal level), be sustained after this project ends?
Response to the evaluation question with analysis of key findings by the evaluation team	The PHR program took several steps to ensure that core programmatic effects could be sustained after the project's end. Qualitative evidence suggests that the implementation of a training of trainer model, support to multisectoral network actors that engaged in advocacy, and tailored support to particular institutions set the foundations in which effects could be sustained. *Qualitative changes that implicate program sustainability* Training-related attitudinal changes among secondary beneficiaries responsible for service provision to survivors within sectors and institutions of both Kenya and DRC was described, which had effects not only on direct encounters with survivors, but also for institutional support (top-down) to local sexual violence programming. By supporting multisectoral relationships, individuals could better navigate patients and engage in broader-reaching and more targeted advocacy efforts, such as making sustained changes to local documentation requirements for survivors. The program also implemented Training of Trainer (ToT) activities in both countries. In the DRC, ToT participants described implementing activities in a variety of settings, including being invited by other NGOs to present knowledge regarding best practices, and also implementing knowledge sharing practices in the neighboring Central African Republic. Curriculum companions and other materials distributed by PHR were deemed useful among secondary beneficiaries responsible for training others in best practices regarding evidence collection and survivor-centered care and treatment. In Kenya, some advanced ToT participants began bringing PHR training curricula into medical and nursing schools, and participants had begun to outline ways in which local educational institutions could change their institutionalized trainings to sustainably replicate the dissemination of best practices in forensic documentation to students of medicine and nursing. These numerous positive strides are mitigated by general resource restrictions in both countries that remain a known and obvious challenge from the outset. *Quantitative trends in the post-intervention period* Post-intervention slopes were examined to gain a better understanding of the direction of trends in the jurisdiction with PHR programming exposure relative to the control jurisdiction.

	Quantitative effects from record review practices reinforced that medical documentation practices (documenting elements such as temperature, location of the incident, and whether the chief complaint "observed section" was filled out) along with legal documentation practices (whether chain of custody documentation was present, whether social assessment reports were filled out for the survivor and perpetrator, and whether there was documentation of whether a condom was used in the medical record within the legal record) were key outcomes on an upward trend in the post-exposure period. Two of the three largest downward trends in the medical record reviews could reflect stockouts in Nakuru, and the largest downward trends in the legal record review remain unclear. Taken together, the quantitative and qualitative findings suggest that the program's impact on forensic documentation practices that appear in records reflect sustained changes in secondary beneficiary behavior that directly implicates services provided to survivors of sexual violence. The program's attention to advocacy building and institutional change efforts is one additional way in which known mitigating structural effects were addressed to allow a more sustainable impact of the project's effects.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	Mixed quantitative and qualitative methods were used to evaluate program sustainability. Medical and legal record review outcome trends (slopes) following program impact were examined, along with secondary beneficiary experiences and perceptions of elements implicating the program's sustainability. Both are described separately, below. QUANTITATIVE EVIDENCE FROM MEDICAL AND LEGAL RECORD REVIEWS While immediate post-intervention effects (and some reporting of considerations regarding post-intervention trends) are described in the Effectiveness and Impact sections of this analysis, this sustainability analysis will specifically focus on the post-intervention trends for the intervention group relative to the control group. To evaluate the record reviews as they pertain to sustainability (as opposed to dedicated attention to the immediate effect following program exposure), we evaluated post-intervention *trend*s derived from the multi-group interrupted time series model: $Y_t = \beta_0 + \beta_1 T_t + \beta_2 T_t + \beta_3 X_t T_t + \beta_4 Z + \beta_5 Z T_t + \beta_6 Z X_t + \beta_7 Z X_t T_t + \epsilon_t.$ Trends were calculated as follows:

- Post-intervention trends in the control group were calculated as b_1+b_3;
- Post-intervention trends in the intervention group were calculated as $b_1+b_3+b_5+b_7$; and
- Differences between intervention and control group trends were calculated as the control effect subtracted from the intervention effect (which is also equivalent to b_5+b_7).

An examination of quantitative trends in the post-intervention period indicate not the immediate nor the temporally-pooled impact of the PHR intervention, but the general trend that can be expected in the intervention group relative to both time and the corresponding temporal trend in the control group. A negative trends indicates a downward trajectory in documentation or thoroughness outcomes, whereas a positive trend indicates an upward trajectory in documentation or thoroughness outcomes. These differences are important to take into account given that both the control and intervention group may move in negative (non-favorable) directions given an unobserved exogenous impact, but where protective effects mitigate the weight of a decrease. The directions should also be interpreted with caution as they may reflect other a number of circumstances beyond the program's control, such as supply stockouts in a locale or other unobserved issues.

Medical record review findings (Table D1)

The difference in post-trend effects for the medical record reviews is presented by item in Table D1. Of all medical record review items examined, 22 of the post-intervention differences moved in a negative direction (ranging from -.123 to -.002), and 33 measures moved in a neutral to positive direction (ranging from 0 to 0.036). Thus, the intervention group was moving in a neutral-to-upward trajectory for the majority of the medical record outcomes examined. Below, we consider the full range of trends for all medical record items and report extreme downward and extreme upward trends.

The largest three downward trends observed were for documentation of informed consent, conducting a high vaginal swab in cases of vaginal sexual assault, and providing PEP. The post-intervention slopes within the intervention group only ranged from -0.045 to -0.026 on these measures, but the larger post-intervention effect size totals were inflated due to positive changes occurring in the control site following the intervention period. It is notable that two of these three items (where the intervention group exhibited a downward trend) depend upon healthcare facilities having supplies available, and it is possible that PEP and specimen collection

stockouts occurred in Nakuru when they were not occurring in the capital.

The largest three upward trends observed were whether the survivor's temperature was documented, whether the location of the incident was reported, and whether the chief complaint "observed section" was filled out. These three measures reflect documentation practices that are behavioral in nature and that are less sensitive to stockouts than the measures exhibiting the largest downward trends. A visual depiction of the chief complaint documentation item relative to the intervention period and time is illustrated in Figure D1.

Legal record review findings (Table D2)

The difference in post-trend slopes for the legal record reviews is presented by item in Table D2. Of all legal record review items examined, 18 of the post-intervention differences moved in a negative direction (ranging from -.033 to -.002), and 14 measures moved in a neutral to positive direction (ranging from 0 to 0.033).

The largest three downward trends occurred for evidence being recorded by a judicial officer, the number of assailants being documented, and adjudication outcomes favoring the survivor. The post-intervention effects within the intervention group ranged from -0.04 to -0.032 on these measures. Given the lag time in processing sexual assault cases, it is difficult to understand why these measures decreased with time, particularly given the immediate post-intervention increases in adjudication outcomes favoring the survivor reported in the Impact section of this report. It is possible that residual documentation issues from the pre-intervention period negatively impacted post-intervention trends.

The three largest upward trends occurred for whether chain of custody documentation was present, whether social assessment reports were filled out for the survivor and perpetrator, and whether there was documentation of a condom being used. These post-intervention total effects reflect relative stability (and possibly resistance to external downward pressures) within intervention group sites whereas control group sites experienced notable declines. A good example of this stability is illustrated in Figure D1 for the social assessment of the perpetrator being present in the legal record.

QUALITATIVE EVIDENCE FROM SEMISTRUCTURED INTERVIEW DATA

Kenya

In the earlier years of the project, interviewees described scenarios where some influential individuals, particularly higher

	ranking police officers, did not consider sexual violence to be an urgent priority for their departments and thus, for their officers. Similarly, some medical professionals considered sexual violence survivors to be "just like the other patients" and "did not consider the specialized needs of these women and girls," which could impact the thoroughness and comprehensiveness of post-rape exams. However, the PHR training was described as making a noticeable impact in what one prosecutor calls, "the culture of sexual assault" among law enforcement and medical officials. These attitudinal effects among trained law enforcement personnel have far reaching consequences that implicate program sustainability, particularly given the central role of law enforcement officers in a sexual assault investigation. Sexual assault, especially against minors, is now more widely considered a major crime and a violation of human rights deserving of urgent action and collaboration. A magistrate described how when police become aware of a sexual assault case, the network "becomes mobilized" and individuals from all the sectors are both motivated and willing to "take extra steps" to ensure a properly handled case. In areas such as Eldoret and Naivasha, stakeholders use a smartphone app like "WhatsApp" to easily keep in contact with everyone at the same time through group chats. The usage of this social media/app was considered more preferable than phone calls or emails because it was faster, although it does require individuals to use their own "data and minutes." Over the course of data collection, several individuals who are part of the on-going group chat through WhatsApp described how they are able to obtain information about specific investigations, updates on survivors and witnesses, and the outcomes of the legal proceedings. Interviewees also suggested that a more informal way of communication made it somewhat easier to get newly transferred-in police and medical officials into the information-sharing network, although these people still stand to benefit from a formal PHR training. PHR training has introduced knowledge into multisectoral networks and thereby improved the capacity for individual actors to both reach out to others and to be receptive to advice given by individuals from other sectors. For instance, prosecutors observed that in many jurisdictions, police would ask prosecutors for advice or direction in what evidence is most probative in a specific case. The advice is given and the working relationship continues. While most of the interviewees had attended some other forms of sexual violence trainings offered by other organizations or in their medical training, these other trainings were largely described as being "too general" and "academic." For many who attended PHR training, it was the first time they had been trained on the specifics of a forensic investigation and evidence collection. Trainings by other

	organizations did not focus on inter-sectoral collaboration. As is now well-known, sectoral isolation was a major obstacle in processing sexual assault cases. PHR's consistent focus on network building, advocacy activities, and trainings thus contributes to the sustainability of cross-sectoral collaboration. One medical officer described, "All of us were in our own little boxes. We did not know what the others were doing and we were in competition with them, we would fight over territory. That does not help anyone!" Some trainees described that their jobs were easier because instead of competing or being antagonistic with other professionals, PHR make showed them that more positive outcomes could be achieved by collaboration. The program did conduct training of trainer sessions, and individuals with advanced knowledge did begin to disseminate knowledge in ways that would be more sustainable in the absence of an external program. As described in greater detail in the knowledge generation section of this impact analysis, colleagues who were trained by PHR shared best practices through Continuing Medical Education (CME) sessions and/or during grand rounds (e.g. with OB/GYN residents). Individuals trained by PHR used case study techniques to help train other colleagues. In the latter period of the project in Kenya, there were a variety of ways in which secondary beneficiaries were sustaining the transmission of best practices, to patients and to other secondary beneficiaries. Some of the transfer mechanisms described were more organized strategic (e.g. through training sessions that were facilitated by previous PHR trainees), and others were less systematic but perceivably effective (providing on the job mentoring on a case-by-case basis). One physician who worked closely with PHR described his vision of incorporating PHR training curricula into Kenyan medical school curricula, and had outlined plans to liaise with the government (MoH/MoE) and in setting up university-based laboratories (with mannequins, instruments) to train Kenyan medical students. One participant described the proposed changes in university-based curricula as an extension of PHR's work with establishing centers of excellence: > We're trying to look at how we can structure, I mean, a part of the hospital to handle, specifically, sexual violence and issues that go with it, in a way that can then be looked at as center of excellence. Now, if with the same zeal and determination PHR can come in and help me work with the universities alongside--I mean, towards achieving this kind of vision, I think that will be very, very useful to me.

	A desire to develop healthcare-facility based sexual violence research capacity was also described. As it concerns research capacity, one participant noted that > Now with curriculum having sexual violence as part of it, and with post-graduates as well getting involved a lot, I'm quite sure that when they're doing their thesis, a lot of work will have to-- they'll be thinking along those lines, getting research activities, and topics, and areas that center or touch on sexual violence. So, it is something that we haven't done much about right now, but I'm looking at the future and seeing a situation where we might end up doing much in that area, especially if we end up grounding it in the curriculum. Separately, as it concerns nursing curricula in Kenya, efforts have already been made to engage the nursing school at the University of Nairobi, where university leadership appear to be in favor of implementing a fellowship aimed at changing policy at the national level. The university senate would need to approve the fellowship if indeed it is going to happen. There was the perception that the fellowship may be too restrictive and that instead, starting forensic evidence training at the BSc or higher diploma level may be a more promising start to better disseminate forensic training over a larger breadth of nursing professionals. It was perceived that nursing students just need a few hours of training spread over the course of several days in which they learn about providing patient-centered care for survivors of sexual assault. The suggested recommendation made for training for BSc nursing students was to allot two hours of training a day over the course of a three-day period (six training hours total). One of the issues is that the time needed to push the issue with the university is all based upon the discretionary efforts of individuals pushing for these changes, whereas having the additional support external organizations behind these particular efforts to engage institutions would be useful. While individuals who worked closely with the program certainly showed discretionary effort to support the sustainability of best practices, several implementation barriers were described. As programmatic activities focused on ToT intersect with standing training structures implemented by various institutions and agencies in Kenya (e.g. medical schools, the police), participants provided various forms of feedback regarding implementation issues and remaining gaps to be addressed as the program moves forward in making its training more sustainable. General “human resource” issues emerged with regard to participants’ ability to run their own training or mentoring sessions.

	While some ToT participants described participating in PHR-funded trainings, some described feeling as though they were provided a mandate to train their colleagues without any time or resources having been budgeted for them to do so. Trainees who may be engaged in mentoring colleagues in some form or another using other organizations' resources described feeling frustrated by both the ToT reporting requirements from PHR, particularly given that they perceive being asked to conduct trainings on their own time. Limited time, inability to provide adequate follow-up, and a lack of supplies and materials to conduct trainings were issues that participants described as frustrating the ToT/mentoring process. While the utility of the PHR curriculum is apparent to trainees, many are overburdened with responsibilities already present in their day jobs/occupational environments and described not have adequate time to plan and implement effective trainings. In the law enforcement sector, there may be an even greater need for systemized training given the repeated commentary regarding how the police, particularly untrained transfers, can decrease case processing efficiency and even create problems for multisectoral network members who have been trained by PHR. The police in particular are a sector where mentoring appears to have instructional value for colleagues who are immediate beneficiaries of the instruction, but where a lack of institutional training and strategy overwhelm the general effect of trainings and mentoring within the police. Police officers still describe the issue of sexual violence as being an issue that men shy away from in law enforcement, and where officers are entering their professions without any training or general awareness regarding forensics in sexual assault investigations. One participant described how "You see now, concerning our service, our police service, you are now placed in that office without the knowledge. So many cases were being withdrawn in court lacking this evidence that is-- they're vital." Engaging law enforcement practitioners who may be able to spearhead training efforts with the General Service Unit and/or the Kenya Police College in Kenyan law enforcement may be one way for the PHR program to better address sustainability of efforts to train the Kenyan police. *DRC* In the earlier portion of the DRC program, secondary beneficiaries commented on how the PHR training changed participants' perspectives and attitudes toward sexual assault and survivors. Some physicians noted that there were discretionary characteristics (e.g. passion, commitment) that were needed among participants to do this type of work in the DRC that were reinforced by the training. In the police in particular, there was the expression

	of pride in one's work following the PHR training, due to its providing actionable techniques, which function well when applied in practice. Some trained police officers felt like "specialists" in sexual assault following the training. One police officer described how > For me and people working in my domain, I can say this is the most specific training I've received, mostly regarding collecting data, I mean evidence in sexual violence. This I can tell you, frankly, that never have we received such a training…[people were] not digging deep in this matter. This gives me courage and gives me motivation to grab the motions PHR was giving. I know that with PHR, with these kinds of trainings, one day I will become a specialist. While attitudinal changes are not a primary target of the PHR training, it is an important precursor to behavior change within one's occupation that could ultimately affect the quality of services received by a survivor of sexual assault. PHR was considered to be producing a more sustainable program in comparison to other NGOs with regard to budget management. Participants noted that something that sets PHR apart from other NGOs working on sexual assault in the region is that PHR program activities do not stop with a funder. There is a comparatively longer and historically legible oral record of PHR's activities in the region, beginning with a core training that has evolved, and including the developments of the medical forensic certificate and MediCapt. The developments of the medical certificate and MediCapt are viewed as logical, continuous extensions concerning a single issue (the forensic investigation of sexual assault in the DRC). Some participants talked about becoming trainers at some point in the near future, hoping to spread lessons learned and best practices into more rural and remote regions of the DRC. Participants described how other NGOs come and go, ending program activities when funding runs out. PHR was perceived as doing a good job adapting the training material to the local context, and not presenting a training that had unrealistic expectations of participants or that was perceived as being too irrelevant (as happens with some other NGOs that have provided training in the region). One physician described how > I think the thing which was different with the Physicians for Human Rights, it was first that the training, all the ideas of training, came from us, you see, from us. They didn't come and bring tools which were already made…we began working on tools together, and tried to adapt the tools which are

	already there in our own context and our own reality. This was really something which was very different… Some participants noted that PHR does not bring "western expectations" to the DRC, and this helps people realistically thinking about applying lessons learned in the local DRC context. This is likely a result of the Sexual Violence Program's continuous presence working on the same topic in the same location. Physicians realized that clinical capacity is greater and more efficient in the United States, and there was the perception that PHR has done a good job adapting activities and developments to the local context by collaborating with local actors who face material restrictions. One ongoing challenge to sustainability of the current program's work is the widespread perception that sexual violence is an issue that foreign NGOs deal with. While participants are aware that DRC is notorious for sexual assault, many participants deal with a large portion of non-sexual-assault-related issues in their day-to-day jobs. For some (not all) participants, there is the perception that DRC receives much unwanted attention due to sexual assault, and that amidst other concerns of living in a developing country, sexual assault is made more salient by NGOs who wish to focus on it. There is the realization among some participants (mostly in the medical sector) that a ToT is one way to continue disseminating lessons beyond the scope of the PHR program (both temporally and geographically). The gap in program relevance that was described for rural survivors was another challenge raised regarding sustainability. It was suggested that well planned ToT efforts could result in more rural personnel being trained such that more personnel in rural locations could implement best practices with rural survivors. One rurally located physician expressed the frustration that personal income/continuity of clinical service is lost during a PHR training, and perhaps alternative perdiem arrangements or different types of onsite trainings could reduce the personal financial loss of attending a PHR training. Rural hospitals need assistance with administrative planning as it concerns sexual assault. There was the perception that there are more equipment and supply stock-out issues in the "red zones" where mass rapes are occurring. One participant noted that the PHR training carries budget implications at the healthcare facility, and that these budget implications need to be addressed if participants are expected to carry out practices in which they have been trained. Equipment, supply, and technological shortages in rural facilities are perceived as relatively worse in rural healthcare facilities in comparison to urban healthcare facilities. One ongoing challenge to sustainability of the program is that rural women are

	not perceived as being willing to follow through with the medico-legal process such that cases result in some type of adjudication outcome. This is an ongoing challenge in the DRC (and one that generally concerns sexual assault crimes in the broader context). Some participants thought that working with tribal leaders as potential network members in more rural regions could help address this issue in order to provide a greater base of support to the survivor. There was the suggestion that PHR should establish a presence in North Kivu (like a small office) to better address implementation challenges such as these. In the latter stages of the program, several trainees had already attended a ToT course and had begun conducting trainings, formal and informal, on topics of sexual violence and evidence collection. These trainings occurred in their local communities and villages, as well as in neighboring countries, namely the Central African Republic (CAR). Interviewees discussed their perceptions of the training and also about their experiences in conducting and facilitating trainings with/for other organizations, such as churches and schools. Newly-minted trainers generally described feeling equipped with both the skills and the will to conduct trainings in their communities and elsewhere, but they did not have the capacity or the means to organize them and arrange the requisite logistics. The following sections address these issues. Few of the interviewees described organizing or facilitating day-long (or longer) formalized trainings on their own, but they almost all participated in "continuing professional education" sessions in their home institutions. Others participated in a training event that was organized and financially supported by some other organization or government agency. The most common venue for ToT participants to organize a training on their own was at their home institutions. For instance, medical staff may conduct informal sensitizations of their colleagues in regularly-scheduled (often monthly) staff trainings. It is often the case that after any professional training, the individual receiving the training will share newly-acquired information and materials with their colleagues in one-to-two-hour informational sessions, depending on the hospital or facility. This was the case in institutions such as Panzi Hospital and Heal Africa. Beyond the trainings at their home institutions, ToT participants were often invited by another organization (such as MONUSCO or a missionary group) or a government agency (such as a unit within the military police) to deliver a presentation on some topic as part of a larger event. The trainer would address topics ranging from general public awareness of sexual violence to highly technical lessons on forensic photography for professionals. The trainer would provide a one-hour presentation on some topic

	and for the most part, would use PHR materials such as a PowerPoint presentation. Sometimes, if appropriate, the trainer would provide handouts for the attendees to take home with them for reference. However, this was only done when the sponsoring organization agreed to provide the photocopies. One trainer said he would offer to email electronic versions of the training materials to the attendees but questioned the efficacy of that approach because most of them did not have regular access to a computer. At these events, the host institutions would provide logistical support, such as inviting attendees, providing a physical space for the training to occur, and providing food and refreshments for trainees. In most cases, but certainly not all, the host organization would also provide a facilitation fee and transport reimbursement for the facilitators. The material support for these trainings is crucial because without it, the trainers themselves would not be able to afford to travel as a volunteer. A lack of resources for logistical support is what was described as keeping many ToT participants from organizing their own larger trainings. Sometimes, their home institutions would provide in-kind support such as providing a space or perhaps bottles of water for participants, but that is as far as that support would go. One magistrate said that the only support her court gives her for training is permission to conduct trainings, but does not make a corresponding reduction in her docket of cases over which she presides. One ToT participant said that she has an easier time organizing "open-house" type events where logistics are less demanding. At these events, members of the general public can stop in, see a few short presentations, perhaps collect promotional items like pens and pencils, and then leave. These events invite the general public, or walkers-by, to enter the no-cost event and learn about sexual violence, and perhaps what to do if one's self or loved one is ever assaulted. The ToT participant stated that these events are easier to organize because she is not inviting specific presenters or attendees but rather having a public information fair. In such circumstances, nobody is reimbursed for their time. When training outside their own institutions, ToT participants were very keen on understanding who their audiences were before their scheduled training began. While they depended on curriculum and materials from PHR for their trainings, ToT participants recognized that their delivery would have to be tailored to their different audiences and to do so effectively, would require some reconnaissance. Before conducting a training, ToT participants typically made an effort to understand the professional and educational backgrounds of their audience members and what material and cultural resources were important to consider in the transmission of

information. There are a few objectives for an effort of this type. First, it sensitizes the trainer to the resource limitations that are experienced by the attendees. This would prevent a trainer from focusing on forensic photography, for example, when it is known that the audience has no access to cameras or printers. Second, it sensitizes the trainer to any cultural and customary issues specific to the locale. For example, one trainer reflected on a time where she conducted a workshop in a rural area outside Goma and found it difficult to discuss female anatomy to religious conservative men who found such discussions to be profane and inappropriate. She said that she could not use visual aids because they were distracting to her audience and some of the male participants felt they were pornographic. Finally, researching recent events helps the trainer to develop a starting point for discussions. In sum, trainers took great effort to understand the material and cultural terrain of their specific audiences and to customize their presentations accordingly. One specific trainer, a police officer, described his process this way:

> When I'm training, I try to bring the learners and the people coming for training to give practical examples from their area, from their tradition, of how they handle, how sexual violence is seen in their area. The second level of practice is when I arrive there, to know how these people behave, I go to see there the local authorities. So that these local authorities receive me. And from that meeting with them, I have an idea of the situation and tradition of that area.

Months before this M&E data collection, PHR conducted a multi-day training on forensic photography for military police in CAR. As part of this training, some ToT participants from DRC facilitated some of the sessions. Considering the fact that these were Congolese trainers in CAR, they quickly identified cultural differences that would have to be accommodated, or at least considered, in future trainings. For instance, one medical ToT participant noted that in CAR there are gender differences in patterns of sexual assault:

> Here [in Bukavu], the percentage of rape survivors, male rape survivors, is so low. It's less than 5%. But there I saw that more than 20% of the victims were men, and they came to say, "I was a victim. I'm a victim of sexual violence." This is not the case we see here, and I learned a lot from that. That should be part of our task. I am used to only women.

In another CAR example, one trainer learned that it was not allowable to interview or photograph a female survivor of sexual assault without a male relative being present and giving his consent. In these situations, the consent of the male relative supersedes the

consent of the female survivor, which poses a troubling challenge if the male relative is the perpetrator or is protecting the perpetrator. This was a factor that had to be incorporated into the training session.

Network coordination issues

The regional network members described struggling with the logistics of planning and holding regular network meetings and events. This is compounded by low participation among some of the members, especially in the judicial sector. Members of both networks described an ebb-and-flow of attendance and participation, but that many individuals would stop coming after two meetings. When asked to speculate as to why some people were no longer attending the network meetings, one interviewee replied:

> It's very difficult. People have done their job at their workplaces. After 3:00, you call them to come here. They don't feel motivated because there is no transport, there is no water, there is nothing. But if we could have at least water to give them, and we don't have money for that, soda to give them-- we don't have money for that. Without these things, we do not look organized.

The North Kivu network indicated that they were working on identifying potential financial backers to help support their ongoing work by funding some of these smaller expenses. They have prepared a list of potential supporters, ranging from humanitarian organizations to churches, from whom to solicit support but they have not yet acted on it. They felt that this was an area where PHR could provide important support; to help facilitate these relationships.

Because of low participation or a lack of regularly scheduled meetings, network members said that they were struggling to maintain even the most basic agenda. A member of the South Kivu network described a situation where the established agenda of network meetings for the previous year was not completed due to low participation or a lack of meeting.

> I'm talking about already a program set up. There was an agenda for last year. Which was not happen. We didn't finish all the topics that we'd planned. So many topics remain, like discussions on DNA tests. We discussed them but we didn't finish the discussions about this DNA. Is it important? When to do it? How to do it? We didn't even finish that. I think it's quick saying what are the other topics which remain? Or need to be discussed? Why we still

	have important topics that we didn't finish discussions on. Scheduling availability and low levels of participation among some of the network members are confounding issues that stymy participation in regular ongoing meetings. Further, a lack of logistical support makes organizing a meeting a difficult task. Discussions about and depictions of the networks by their members presented somewhat conflicting images. On one hand, the networks have dedicated members who maintain regular contact with other members via chat or instant messaging regarding case-specific issues and attend meetings consistently. On the other hand, members also described situations where there is low interest, low participation, and periods of time with no scheduled meetings. These conflicting claims were noted by a member of the North Kivu network who felt that the leaders of the South Kivu network were overstating their activities and accomplishments, "They say they accomplish so much, but that is only talk, where is proof? How many members do they actually have?"
Conclusions	From the outset, the PHR program worked in two countries with resource and structural constraints that otherwise mitigate individual behavioral changes that any program could achieve within secondary beneficiaries. The program intervened in these complex local contexts while simultaneously continuing training and trainer of trainer activities that carry their own effects. Trainees described improvements in attitudes toward survivors of sexual assault following the program, which also affected institutional support for local sexual violence programming. Record review results reinforced that particular medical documentation practices and legal documentation practices were key outcomes that were in the process of being improved on an "upward" or "resistance to otherwise negative effects" trajectory following the intervention period, but temporal variation in outcomes in the control site and country-wide resource restrictions may simultaneously produce exaggerated effects for this particular analysis. Taken together, the quantitative and qualitative findings suggest that the program's impact on forensic documentation practices that appear in records reflect sustained changes in secondary beneficiary behavior that may be disseminated to other secondary beneficiaries with diminishing doses through a training of trainer model, with modest evidence of institutional or structural change that may support positive behavioral changes throughout the future.

Table D1. Multiple-group interrupted time-series post-trend results derived from medical record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya*

Medical record item	Control group trend following intervention	Intervention group trend following intervention	Difference
Documentation of informed consent	0.088	-0.035	-0.123
High vaginal swab conducted (if assault was vaginal)	0.037	-0.026	-0.063
PEP first dose given	0.013	-0.045	-0.058
Documentation of prior health facility attended	0.009	-0.027	-0.037
No data missing from swab domain	0.020	-0.017	-0.037
Documentation of whether reported to police	0.009	-0.024	-0.033
Age of perpetrator documented	0.000	-0.028	-0.028
ECP given	-0.004	-0.030	-0.027
Documentation of whether survivor left marks on perpetrator	0.004	-0.017	-0.020
Number of perpetrators documented	0.004	-0.013	-0.016
Comments section filled out	-0.002	-0.013	-0.011
Pulse rate documented	-0.011	-0.020	-0.009
Anal swab conducted (if assault was anal)	0.010	0.002	-0.009
Blood pressure documented	-0.011	-0.019	-0.008
Relation of perpetrator to survivor documented	-0.005	-0.013	-0.007
RR documented	-0.016	-0.024	-0.007
Received a pregnancy test (if female)	0.002	-0.004	-0.006
Outer genital swab conducted	0.002	-0.002	-0.004
DNA sample sent to laboratory	0.002	0.000	-0.002
Samples were packed and issued	0.000	-0.002	-0.002
STI treatment given	0.004	0.002	-0.002
Referrals provided following Part B	0.000	-0.002	-0.002
Gender of patient documented	0.000	0.000	0.000
Body maps were completed	0.000	0.000	0.000
Genital examination of survivor complete	0.002	0.002	0.000
Referrals provided	0.000	0.000	0.000
Urine tests conducted	0.000	0.000	0.000
Forensic photography present in medical record	0.000	0.000	0.000
Documentation of whether survivor bathed	-0.005	-0.004	0.002
Name and signature for police officer	0.000	0.004	0.004
Date for police officer's signature	0.000	0.004	0.004
Demeanor/level of anxiety documented	-0.006	0.000	0.005
Date and time of incident documented	-0.007	-0.002	0.005
Marital status documented	-0.005	0.000	0.005
PRC form is dated	-0.005	0.000	0.005
Section "circumstances surrounding incident" filled out	-0.005	0.000	0.005
Type of sexual violence documented	-0.005	0.000	0.005
Known pregnancy documented	-0.020	-0.015	0.006
Name and signature for examining officer present	-0.006	0.000	0.006

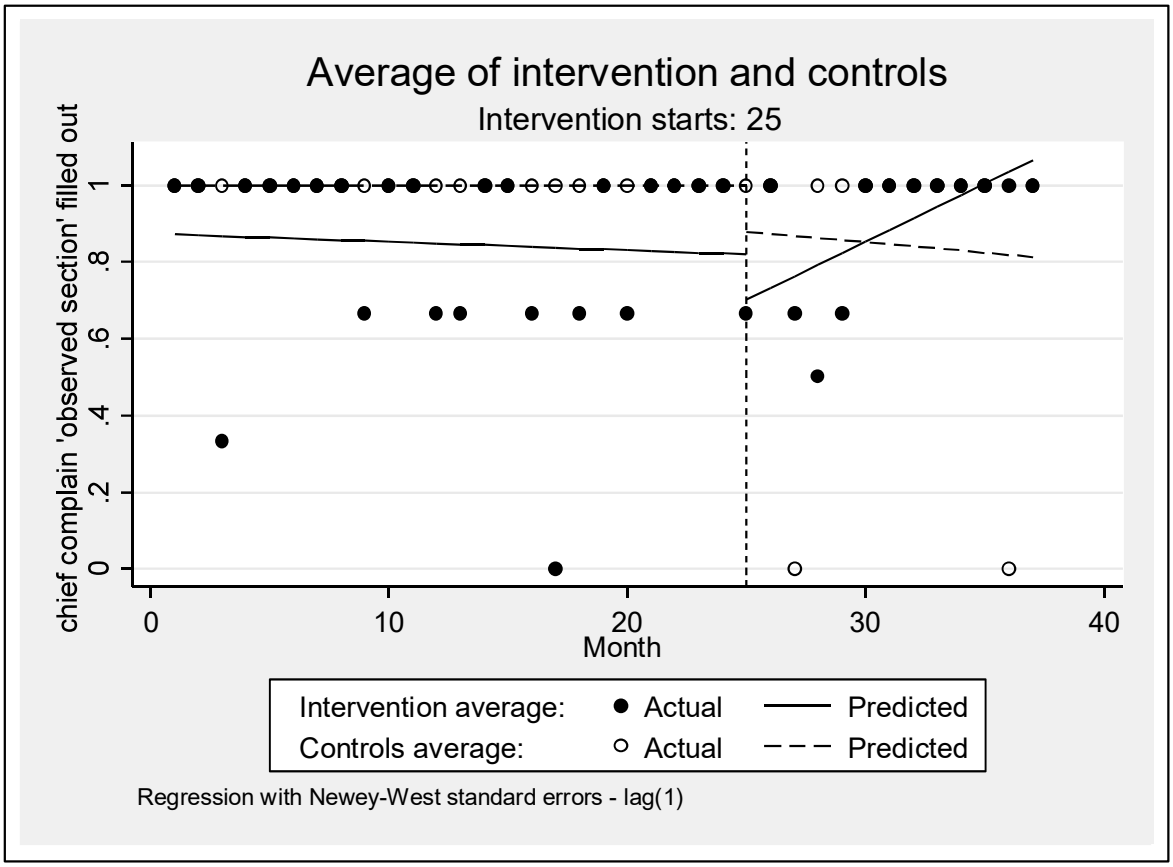
Results from Table D1 continued on next page

Table D1 continued…

Medical record item	Control group trend following intervention	Intervention group trend following intervention	Difference
Date for examining officer's signature present	-0.006	0.000	0.006
Chief complaint "incident" section filled out	-0.002	0.007	0.009
Date and time of exam documented	-0.005	0.004	0.009
Received an HIV test	-0.011	-0.002	0.009
Part B of PRC form complete	-0.011	-0.002	0.009
Method of transporting clothes documented	-0.011	-0.002	0.009
Whether clothes were handed to the police documented	0.000	0.011	0.011
Condom use documented	-0.027	-0.015	0.013
Whether survivor changed clothes documented	-0.005	0.007	0.013
DOB documented	-0.018	-0.005	0.013
Received a VDRL	-0.018	-0.004	0.015
Documentation of whether survivor used toilet	-0.015	0.002	0.017
State of clothing documented	0.000	0.018	0.018
Temperature documented	-0.011	0.009	0.020
Location of incident recorded	-0.005	0.015	0.020
Chief complaint "observed" section filled out	-0.005	0.030	0.036

**Results were derived from a model*
$Y_t = \beta_0 + \beta_1 T_t + \beta_2 T_t + \beta_3 X_t T_t + \beta_4 Z + \beta_5 Z T_t + \beta_6 Z X_t + \beta_7 Z X_t T_t + \epsilon_t$*, where:*
Post-trend control group effects were calculated as b_1+b_3*,*
where intervention group effects were calculated as $b_1+b_3+b_5+b_7$*, and*
where differences were calculated as the control effect subtracted from the intervention effect, which is also b_5+b_7

Figure D1. Pre and post-intervention effects for control and intervention groups on the chief complain "observed section" being filled out in the medical record over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya*



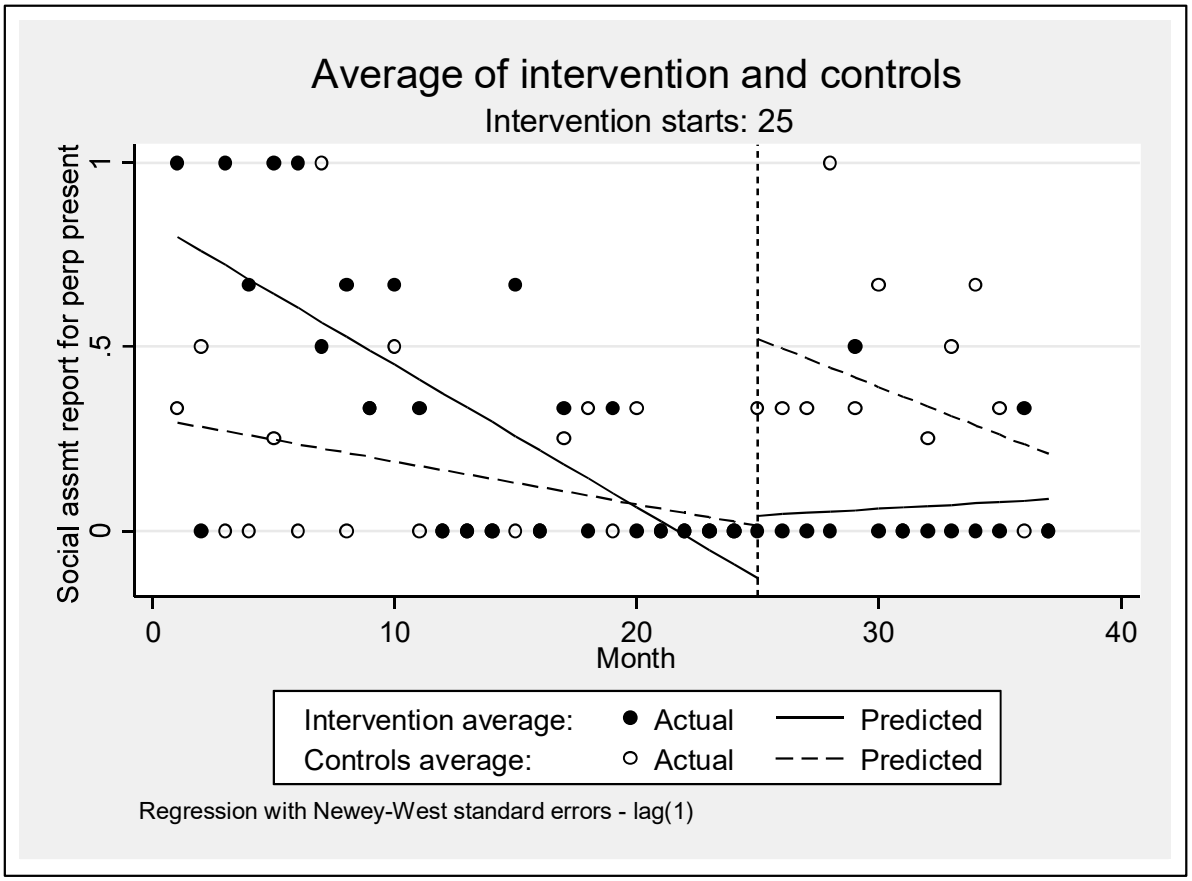
**Results are derived from a multi-group interrupted time series analysis*

Table D2. Multiple-group interrupted time-series post-trend results derived from legal record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya*

Legal record item	Control group trend following intervention	Intervention group trend following intervention	Difference
Evidence recorded by judicial officer	-0.007	-0.040	-0.033
Number of assailants documented	0.000	-0.033	-0.033
Adjudication outcome / ruling favoring survivor	0.000	-0.032	-0.032
Estimated age of perpetrator present	0.028	0.000	-0.028
Survivor's age was documented	0.021	0.000	-0.021
Date of conviction present	-0.007	-0.019	-0.012
Is a PRC form present	-0.006	-0.017	-0.011
Date and time of the incident documented	-0.011	-0.022	-0.011
Number of perpetrators present	-0.017	-0.022	-0.006
Documentation of whether incident reported to the police	-0.016	-0.022	-0.006
Section "circumstances surrounding the incident" filled out	-0.017	-0.022	-0.006
Chief complaint "reported" section filled out	-0.016	-0.022	-0.006
Survivor attended a health facility before this one	-0.016	-0.022	-0.006
Date and time of examination documented	-0.017	-0.022	-0.005
Location of the incident recorded	-0.017	-0.022	-0.005
Body maps were completed	-0.017	-0.022	-0.005
Charge sheet present	0.002	0.000	-0.002
Parental statement for child's age (for child case)	0.005	0.004	-0.002
Date assault was reported documented	0.000	0.000	0.000
Name of the offence committed present	0.000	0.000	0.000
Photograph of convict	0.000	0.000	0.000
Physician testified	0.000	0.000	0.000
Part B of the Medical Record Complete	0.000	0.000	0.000
Forensic photography present	0.000	0.000	0.000
Report from government chemist present	0.000	0.000	0.000
Age assessment report present (for child case)	0.000	0.000	0.000
Other labs present	-0.007	-0.003	0.005
Age of perpetrator present	-0.007	0.000	0.007
Chain of custody documentation present	-0.012	0.000	0.012
Social assessment report for survivor	-0.024	0.000	0.024
Social assessment report for perp	-0.026	0.004	0.030
Documentation of whether a condom was used	-0.039	-0.006	0.033

**Results were derived from a model*
$Y_t = \beta_0 + \beta_1 T_t + \beta_2 T_t + \beta_3 X_t T_t + \beta_4 Z + \beta_5 Z T_t + \beta_6 Z X_t + \beta_7 Z X_t T_t + \epsilon_t$, *where:*
Post-trend control group effects were calculated as b_1+b_3,
where intervention group effects were calculated as $b_1+b_3+b_5+b_7$, *and*
where differences were calculated as the control effect subtracted from the intervention effect, which is also b_5+b_7

Figure D2. Pre and post-intervention effects for control and intervention groups on social assessment report for perpetrator being present in the legal record over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya*



**Results are derived from a multi-group interrupted time series analysis*

3.5 Impact

Evaluation Criteria	Impact
Evaluation Question 5	To what extent has the project contributed to ending violence against women, gender equality, and/or women's empowerment (both intended and unintended impact)?
Response to the evaluation question with analysis of key findings by the evaluation team	Various perceived (qualitative) and directly observed (quantitative) improvements in medical forensic documentation thoroughness and adjudication outcomes were associated with exposure to the PHR program. These changes reflect changes that directly impact a survivor's ability to pursue justice, thereby impacting a survivor's Justice accessibility (a key step in ending violence against women). *Experiences with survivor-level impact* Qualitative interviews with secondary beneficiaries included increased perceptions of perpetrator convictions in both Kenya and the DRC, and secondary beneficiaries provided specific examples where improvements in the knowledge and practice of collecting forensic evidence translated into outcomes in the justice sector. In Kenya, legal sector trainees and network members perceived that increased conviction rates were occurring following interaction with the PHR program, and described the perception that in jurisdictions with more successful prosecutions, there were more survivors reporting incidents to police. Individuals who remained connected through multisectoral networks described more effectively leveraging their networks to navigate sexual violence survivors' cases through the multisectoral environment as a result of PHR's programmatic involvement. Individuals who were trained in the advanced pediatrics training described providing more attention to the child's narrative and placing less emphasis on whether the hymen was torn. Medical sector participants described the perception that the judiciary was adding more weight to physical exam documentation. In Kenya, unintended consequences described by secondary beneficiaries included perceptions of increased safety as a result of being better connected within multisectoral networks, and the added benefit of being able to identify evidence that has been tampered with (which is not a training directive, but an outcome of having more knowledge regarding forensic examination techniques). In the DRC, there was also the perception among secondary beneficiaries that an increased number of convictions was occurring. In comparison to the many nongovernmental organizations working on the topic of sexual violence in the DRC, PHR was described as being uniquely impactful in the topic of forensic medicine, and was particularly known for its focus on the development and appropriate use of the forensic certificate (a particularly probative element in cases of sexual assault in the

	eastern DRC where DNA testing is not possible through the state's resources). In the DRC, unintended consequences included the application of forensic investigative techniques to other exams and cases (outside of sexual assault), physicians testifying less in court as a result of improved understanding of the medical forensic certificate, and impacts of personal security. Across sectors in the DRC, there was the perception that increased occupational performance in sexual assault investigations resulted in more secondary beneficiaries receiving unwanted attention from perpetrators under investigation. *Evidence of impact in medical and legal records* Directly observed effects regarding impact associated with the program were observed across the medical and legal record reviews in Kenya. This included significant increases associated with post-program exposure in Part B of the PRC form being complete, the completion of a VDRL test, and high vaginal swabs being conducted (if the assault was vaginal) in the medical record reviews. In the legal record reviews, all of the medical forensic documentation outcomes examined moved in a favorable (upward) direction immediately following program exposure, and date and time of the incident being documented in the medical record was appreciably elevated within legal records. Appreciable increases in adjudication outcomes favoring the survivor were also observed in the legal records in the period immediately following exposure. This final finding corroborates the perception among interviewees that more convictions were occurring. A posthoc analysis of legal records illustrated that more complete medical forms within the legal records were associated with a greater likelihood of an adjudication outcome favoring the survivor.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	The evidence gathered to address the impact evaluation criteria was both quantitative and qualitative. Quantitative data in Kenya included medical and legal record reviews, as well as estimates derived from program record monitoring data. Qualitative data were derived from the experiences of healthcare, law enforcement, and legal sector trainees and program participants in conducting investigations and in providing services to survivors of sexual assault. Record review findings are presented first, followed by qualitative data findings and finally, estimates derived from programmatic data. QUANTITATIVE EVIDENCE FROM MEDICAL AND LEGAL RECORD REVIEWS Select items from medical and legal record reviews were examined to determine whether the program was associated with an

	improvement to medical forensic documentation outcomes in the medical records, improvement of adjudication outcomes in the legal records, and improvement in medical documentation that was evident *within* legal records. Improvements in medical forensic documentation thoroughness and adjudication outcomes in intervention sites reflect changes that directly impact a survivor's ability to pursue justice, thereby impacting a survivor's ability to access Justice (a key step in ending violence against women). Medical record forensic documentation variables that were analysed for the impact section of the evaluation included whether: *Body maps were completed;* *The survivor's clothes were handed to the police;* *Samples were packed and issued;* *A genital examination of the survivor was complete;* *A PEP first dose was given;* *An ECP was given;* *STI treatment was given;* *A DNA sample was sent to the laboratory;* *Part B of the PRC form was complete;* *Referrals were provided following Part B of the PRC form;* *Assent of the minor was noted;* *Consent of parent/guardian was noted for cases involving minors;* *The survivor received a pregnancy test (if female);* *The survivor received an HIV test;* *The survivor received a Venereal Disease Research Laboratory (VDRL) test to screen for syphilis;* *An outer genital swab was conducted;* *An anal swab was conducted;* *A high vaginal swab was conducted; and* *No data was missing regarding swabs collected.* Medical forensic documentation variables were also examined *within* legal records, and included whether: *The date and time of the examination was documented;* *The date and time of the incident was documented;* *The number of perpetrators was documented;* *The location of the incident was recorded;* *The chief complaint "observed" section was filled out;* *The chief complaint "reported" section was filled out;* *The section "circumstances surrounding the incident" was filled out;* *There was documentation of whether a condom was used;* *Documentation of whether the incident was reported to the police;*

	The survivor attended a health facility before this one; and *Body maps were completed.* Finally, legal records were examined for adjudication outcomes favouring the survivor. Adjudication outcomes that did not favour the survivor included cases that were dismissed or acquittals of the perpetrator. Outcomes that favoured the survivor included the following outcomes: • *Guilty of Defilement;* • *Accused charged with offence of defilement contrary to section 8 (1) and 8(4) of the sexual offence act;* • *Accused person charged with the offence of attempted defilement contrary to section 9(2) of the sexual offences act;* • *Offender charged with defilement contrary to section 8(1) as read with section 8(2) of the sexual offences act no. 3 of 2006;* • *Defilement contrary to section 8(1) as read with section 8(2) of the sexual offences act no. 3 of 2006;* • *Found guilty, 10 years imprisonment;* • *10 years imprisonment;* • *indecent act with a child;* • *Accused person found guilty according to section 9(1) as read with section 9(2) of the sexual offences act no. 3 of 2006 laws of Kenya. Alternative charge 11(1) of the sexual offences act no 3 of 2006;* • *15 years imprisonment;* • *Accused found guilt for defilement and placed under probation for six months under supervision of Probation office;* • *Accused sentenced to 20 years imprisonment;* • *Accused found guilty of the said offence and proceed to convict him pursuant to section 215 of the criminal procedure code;* • *10 years imprisonment;* • *The accused found guilty under section 8(1) as read with section 8(2) of the sexual offences act. The accused convicted of the said charge pursuant to section 215 of the criminal CPC;* • *The prosecution has proved its case beyond reasonable doubt on the charge of attempted defilement contrary to section 9(1) as red with 9(2) of the SOA. Accused found guilty of the said offence and convicted pursuant to section 215 of the CPC;* • *Perpetrator sent to probation;*

	• *The report submitted is positive. The subject shall be placed under probation for 2 years. R/A 14 days;* • *P.O.R carefully considered. The subject is hereby sentenced to a probation term of 2 years. R/A 14 days;* • *Accused found guilty of offence of defilement contrary to section8(3) of the sexual offences act;* • *Accused person sentenced to fifteen years imprisonment under section 8(4) of the sexual offences act no 3 of 2006; and* • *6 months imprisonment plus Kshs 30,000 fine.* Tables E1-E8 at the end of this section illustrate results from the multiple-group interrupted time-series. Appreciable effects regarding impact associated with the program were observed across the medical and legal record reviews. This included significant increases within the medical record reviews for Part B of the PRC form being complete, the completion of a VDRL test, and high vaginal swabs being conducted (if the assault was vaginal). In the legal record, all of the medical forensic documentation outcomes examined moved in a favorable direction when associated with program exposure, and date and time of the incident being documented in the medical record was appreciably elevated within legal records. Appreciable increases in adjudication outcomes favoring the survivor were also observed in the legal records. *Part B of the PRC form being complete in the medical record (Table E2)* As shown in Table E2, the initial mean level difference between Nakuru and Kibera was significant, but the difference in the mean baseline slope was not, suggesting that the intervention site actually started worse off than the control site prior to the intervention period as it concerns Part B of the PRC form being complete prior to the PHR intervention. A statistically significant treatment effect was observed during the first intervention month (+0.58 percentage point increase in part B of the PRC form being complete). *The completion of a VDRL test in the medical record (Table E3)* As shown in Table E3, the initial mean level difference between Nakuru and Kibera was not significant, nor was the difference in the mean baseline slope, suggesting comparability of the control and intervention cohorts on the completion of a VDRL test. There is a statistically significant treatment effect during the first intervention month (+0.48 percentage point increase in the receipt of a VDRL test).

	High vaginal swabs being conducted (if the assault was vaginal) in the medical record (Table E4) As shown in Table E4, the initial mean level difference between Nakuru and Kibera was not significant, nor was the difference in the mean baseline slope, suggesting comparability of the control and intervention cohorts on high vaginal swabs being complete. There is a statistically significant treatment effect during the first intervention month (+0.82 percentage point increase in the collection of high vaginal swabs if the assault was vaginal). Further analysis revealed a slight decrease in the postintervention period among Nakuru cases by -0.03. *Date and time of the incident being documented in the medical record within the legal records (Table E6)* As shown in Table E6, the initial mean level difference between Nakuru and Kibera was not significant, nor was the difference in the mean baseline slope, suggesting comparability of the control and intervention cohorts on medical documentation of date and time of the incident within legal records. There is a statistically significant treatment effect during the first intervention month (+0.84 percentage point increase in medical documentation of date and time of the incident within legal records). *Adjudication outcomes favoring the survivor in the legal record (Table E5)* As shown in Table E5, the initial mean level difference between Nakuru and Kibera was not significant, nor was the difference in the mean baseline slope, suggesting comparability of the control and intervention cohorts on adjudication outcomes favoring the survivor. There is a statistically significant treatment effect during the first intervention month (+0.38 percentage point increase in adjudication outcomes favoring the survivor). Further analysis revealed a slight decrease in the postintervention period among Nakuru cases by -0.03. We conducted one post-hoc analysis to further explore the relationship between adjudication outcomes and PRC form completeness in the legal record reviews outside of the interrupted time series framework. Within all cases examined for the intervention site (Nakuru) within the post-intervention period (n=30), each additional element of PRC documentation examined that was complete within the legal record was associated with a 1.3 increase in the odds of an adjudication outcome favoring the survivor of sexual assault (OR=1.35, 95% CI 1.1-1.7, p=0.009) (see Figure E1).

QUALITATIVE EVIDENCE FROM SEMISTRUCTURED INTERVIEW DATA

Semistructured interviews with secondary beneficiaries revealed different ways in which program activities had direct effects on survivors of sexual assault, as well as unintended consequences of the PHR program.

Kenya

Prosecutors in Kenya described observing an increase in successful convictions, and attribute this increase to PHR training. One prosecutor gave the following estimate for cases over the past calendar year,

> It's high. It's high. It's around, I'd say 50, 55 percent, which is higher than before. Especially now that law enforcement knows what is required, the medic knows what is required. The conviction rate is very high.

Interviewees from all three sectors stated that, as a result of the trainings, more sexual violence survivors are reporting incidents. Interviewees attributed this rise in part to the publicly visible increase in prosecutions. One officer described how "…people responded positively, they reported more cases within the police station. People now stop the shying away from the reporting." In a different interview, another officer noted, "And due to the increase of these cases being reported, they are also now becoming more aware to ensure that the perpetrators of these offenses are brought to book."

Several prosecutors made the conjecture that the stigma associated with sexual violence is weakened by the greater visibility of prosecutions. As perpetrators are being held accountable and are being sentenced to prison, it is easier to combat the idea that women and girls are responsible for their own attacks. As one legal professional described,

> I think [a conviction] helps them move on. They'll be able to help another survivor somewhere. Something happens to someone they know and because I got a conviction out of my case I tell them, "There's hope for you. This is what you're supposed to do." They'll take them through the process. So they'll be out there advocating for us that there's hope.

A nurse corroborated this idea that more survivors would be willing to step forward and report sexual violence because they would understand that there is "a team willing to listen and help her." The perceived effects of more convictions on survivors' perceptions of the justice system and corresponding willingness to come forward is a notable finding of this evaluation.

	Law enforcement trainees provided several examples of cases that resulted in a successful conviction following the PHR training, where there was the perception that the cases would otherwise have not been successful if it were not for the PHR training. Several of these anecdotes are described below. One case that was described by several interviewees concerned an electrician who sexually assaulted a woman while she was home alone. A magistrate, the investigating officer, and a prosecutor all described this particular case as a success in forensic investigation. Without strong evidence collection skills among PHR-trained police officers, it is generally thought that this case would have been dismissed for lack of evidence. The officer described the case in this way: > And the lady was, I believe-- it was very early in the morning, she had not prepared well, she was in a nightdress. And after that the lady came to my police station. She reported the matter, I escorted her up to the hospital here, she was treated, there were a lot of evidence, there were spermatozoa, there was everything, and then after that I managed to proceed to Kenya Power offices, where I requested the manager to avail all the staffs to an ID parade. The manager actually complied, there was an ID parade. The lady managed to identify the suspect. And in the survivor's house, there was a cat - a small cat. The cat used play with the perpetrator, and you know, when you play with a cat, after sometime, the cat leaves hair on your clothing. I managed to retrieve four pieces of hair on the clothing of the perpetrator, and I managed to connect that, 'At one particular time, you were in this house.' Because this cat's-- actually the color of the hair, resembles that recovered from the suspect's clothing. The above case illustrates how a trained law enforcement officer took an active role in evidence collection to corroborate a survivor's narrative. In another case, where a father raped his young daughter, he was found guilty but then appealed the ruling. The strong evidence resulted in the higher court upholding the lower court's decision. The investigating officer gave the following account: > [B]ecause it was a well investigated case, I collected evidence within two and a half hours, probably immediately after the offense was committed. So the perpetrator had not even taken bath. So I had a lot of evidence, and the trial magistrate jailed the perpetrator for 25 years, the perpetrator managed to

	appeal the case, it was taken to the High Court. We went again to the High Court, we provided the evidence, the magistrate, the trial judge upheld the sentence of 25 years. In these examples, not only is there a tangible outcome for the survivor, but secondary program beneficiaries in the network see and experience the effects of a successful investigation within the justice system. This was perceived to have a recursive effect on their trust in their newly implemented practices. Several of the secondary beneficiaries participating in multisectoral networks in Kenya operate what is called a "Court Users Committee," which is comprised of stakeholders from different sectors. It is intended to serve as a multisectoral network of professionals where professionals can collaborate on cases across sectors and trouble-shoot problems as they pertain to cases that have gone to trial. However, in some areas the committee was not meeting regularly and the members did not all know each other. Further, members were communicating about cases after they had already gone to trial and by that time, there was little to be done to keep a case from being dismissed. Many interviewees lamented the weak efficacy of the committee, which changed after PHR training when they were able to meet each other and find ways to collaborate before cases went to trial. As one member described: We have something we call the Court Users Committee…these are stakeholders of the users of the court who, when we meet, we discuss a number of challenges, a number of issues which affect the delayment [sic] of cases in court on and on, and actually, those are the members also in the PHR training. We now talk to each other more often and know each other better. We drop less cases now because we can connect more easily. As it was described, this previously existing network expanded its capacity to work on pending cases and cases in trial following exposure to the PHR program. It has increased the frequency and scope of interactions amongst its members and ultimately reported dropping less cases as a result of increased communication and coordination. There were general perceptions that the advanced pediatrics training (APT) in Kenya also resulted in alterations in documentation practices that improved case outcomes in the justice sector for child survivors of sexual assault. In part, this effect was perceived to be mediated by alterations in the documentation practices of physicians following the APT. Physicians described shifting their attention from the hymen to instead focusing on the

	results of the physical exam (including injuries) and documentation of the child survivor's narrative. One physician described how > Initially, I wouldn't know how to, for example, indicate injuries, the terms to use…I would, for example, just say, "There was an injury in the genitalia at this position." But after the training, I will be more specific. For example, I'll say, "There was a bruise at the five o'clock position. There was a laceration in the hymenal ring," and so on. So that aspect of being detailed and specific came out quite well after the training. It was perceived that in response to these changes in documentation practices, that the judiciary began adding more weight to the history, physical exam documentation, and laboratory test results as opposed to simply whether the hymen was broken. Some physicians described that it was easier to present evidence in court, and to provide expert testimony in court. One physician described how > There was one case whereby the perpetrator was arrested the same day after the act as he was trying to run away. He was arrested. He was assaulted by the mob before being brought to the hospital. So, we collected all the information that was required, also filled the psychiatric assessment, and then went to court, presented all the documents. And the child was there, the mother was there, because they had already given the evidence. They just wanted to listen to what the doctor was to present. Perpetrator never had any question to ask. I'm the one who examined the perpetrator. I'm the one who examined the child. Luckily, the police officer brought the two of them to the facility for examination. Yeah. And the injuries the girl had inflicted on the perpetrator were well documented and captured both from the perpetrator and the information from the child. So, when I presented the PRC form…the perpetrator had no question to ask. So, they felt like whatever was captured while they we giving it had been presented the way it was. And this is a case that came up I think almost a year after the incident had occurred. So, when they had the same information as declared the way they had given it, they were really happy. The mother came and said, "Thank you for that." Another physician described how > Especially for the-- children between the age of 12 years and above who are fluent in what they're

	saying, when you fill the psychiatric part and then present it in court, present the history they have given, your physical findings, then the laboratory works, then you relate and make a-- it's more of an impression that your features are highly consistent to sexual assault, it has more weight. Because initially what we used to do was just present and then you-- at times you don't give that conclusion. And then it's like you have the left the judge to decide. But right now, you can make an impression and say, "This one is highly consistent with sexual assault or defilement. Or consistent or no-consistent." There was also the perception from APT medical provider trainees that child sexual assault cases were being processed more efficiently in the judicial sector following the advanced pediatric training. Interviewees' perceptions of increased personal safety was an unintended consequence of training participation and multisectoral networking that occurred for secondary beneficiaries conducting more thorough investigations that were perceived to have resulted in more convictions of perpetrators. Several interviewees acknowledged that they sometimes felt nervous about their role in successfully convicting sexual violence perpetrators, but none expressed outright fear for their safety. One prosecutor described a time where she was confronted by a defendant's family members in the market. She explained to them that it was not her personally that was working against the defendant, but rather that she was just doing her job and the evidence spoke for itself; she was merely a technician. No interviewees described situations where they felt afraid for their lives or their personal safety, although this perception has arisen in previous evaluations. During this evaluation, interviewees described threats as "part of the job," or explained that "these threats are often the price of getting justice for these women." While not something that was directly addressed in PHR training, some stakeholders indicated that as a function of their more rigorous evidence collection and frequent contact with others in their networks, they can more easily identify evidence that has been tampered with or compromised. One prosecutor gave the following example of a case that was dismissed, in his opinion, because the evidence was changed either by a police officer or a medic who was likely bribed, [W]hat happened is when I went to present this in court, I had a P3 form which was positive and it included that a minor had been defiled- So this was a positive citation that the child had indeed been defiled. But the shock I got in court is when the defense had a P3 form which indicated that there were no injuries on the

	genitalia. It was unfortunate we lost the case because the P3 form they had was the original. We only had a copy that was supplied to us by the mother of the complaintant. A magistrate from a different community lamented similar situations, but stated that now he and other legal professionals can now easily, and with more confidence, identify evidence that has been tampered with, which has been an ongoing challenge: Somebody was changing the P3 forms. This can normally take place at the police station or even at the medical facility where somebody can actually give money to the officer who is filling out the P3 form - Or they can even give one member of staff money so they can add to the P3 form. But with the PRC form that is more difficult. Also, I can tell if a form has been tampered with because the information will be inconsistent or left out. An incomplete PRC form is a major red flag in court because we know the medics fill it out completely. *DRC* There were various perceptions across sectors on the reach of the PHR program. In the legal sector, several magistrates estimated that of the sexual assault cases they have seen since participating in the initial trainings held by PHR, that the majority of cases (>50%) resulted in a conviction. One magistrate had the perception that the number of perpetrators was decreasing as a result of law enforcement adequately doing their job. The improvement in successful convictions is perceived to be in part due to the effect of PHR, but it was described as difficult to distinguish from the effects of other organizations working on sexual violence in the region. Magistrates reiterated that improvements in medical reporting and appropriate use of the forensic certificate are key elements of a case that are useful in convicting a perpetrator of sexual assault, and that poorly written medical reports result in case dismissals and freed perpetrators. PHR is primarily referenced as the organization doing substantial work to rectify these issues. One magistrate explained how matching the victim's narrative with the medical certificate is the strongest evidence for a sexual assault case that arrives in court in the DRC. Magistrates explained that additional evidence arriving in sexual assault cases is something can be attributed to PHR. One magistrate suggested that video evidence of the survivor providing a narrative could be very useful in court. The magistrate provided some additional considerations on the topic of video testimony: It can help fill some gaps. Still, it has too much with our laws. Does our law allow us to film somebody? If yes, then we have to respect confidentiality. Does the victim accept to be filmed? Does she consent for

	her to be-- does she consent to be filmed? It depends upon her. If she accepts then we have the right to-- it's good to film. But if she doesn't accept we have to respect her dignity, her confidentiality and [?]. So, everything will depend upon her. There was the perception that physicians filling out forensic certificates correctly and the overall reduction in ambiguity amongst sexual violence cases is what is perceived to be the PHR-driven effect impacting survivors' cases locally in the DRC. There are still perceived gaps in obtaining the necessary evidence to convict perpetrators in court. One lawyer noted that testimonies provided by both healthcare and law enforcement sectors could be improved in court – sometimes they are not detailed enough about the type of examination or investigation they conducted, and this benefits the perpetrator's case. Further, there remain major gaps in reparations for survivors. One magistrate explained how sexual violence cases with financially poor perpetrators more frequently go to court, because perpetrators with greater financial means can bribe the survivor's family not to take the case to court. Unintended consequences of the training in the legal sector include using or requesting forensic investigative practices in cases that do not include sexual assault, and increased security risks for lawyers and magistrates/judges working on sexual violence cases. There were multiple reports of lawyers receiving threats from armed groups during mass crimes investigations in which the lawyer was attempting to be as thorough as possible. One magistrate described how doing a better job in an investigation places extra unwanted attention on the judge from the perpetrator, and this is a perceived security risk. Police officers in particular were able to link improved investigative techniques to seeing a perpetrator of sexual assault sentenced. Some perceived that more perpetrators were being convicted as a result of the more thorough investigations being conducted. One police officer described how This training had a big added value in my work as a police officer. Before, I could investigate, arrest, send the file to the court, but some days after, I could see that the perpetrator is freed. He was freed, the court said he was freed because of lack of enough evidence. But since I got this training, I bring enough evidence capable to bring light to the court so that they can prosecute and sentence the perpetrator. What is unique for the trainings from PHR is to improve the language of different interveners in the sexual violence domain… [PHR is] the only organization which puts together

	lawyers, magistrates, police officers, psychologists, and other actors to speak the same language and understand each other's jargon when it comes up to cases of sexual violence. Some police had the perception that survivors are more trusting to come forward with their cases as a result of the perceived increase in convictions and sentencing of perpetrators. One police officer described how There are victims who never came because they did not trust the whole system. But the way we learned to keep their confidentiality, welcome them, talk with them, it gives them trust. These victims go and tell the people in the community, and other people now come to us. And this is a big thing, because there was this reinforcement of trust. Several police had the perception that the medical certificate and the survivor's narrative are the weightiest elements of evidence in a sexual assault case in the DRC (this observation was also made by participants in the judicial sector). Police describe that in other parts of the country, medical certificate implementation will be challenged by a lack of policy mandating use of the medical certificate nationwide, and a lack of knowledge among practitioners on how to use it. In the absence of DNA analysis, some police officers think that video testimony of the survivor could be useful in court (to corroborate the survivor's identity and in cases where the survivor may deny the narrative in court). One police officer described how vaginal swabs from sexual assault cases were currently stored at the prosecutor's office in Bukavu, however it remains unclear why these swabs are being stored and when they can expect to be analyzed. Unintended consequences reported by law enforcement participants included training others on the job in forensic investigative techniques, and a personal threat to security. One police officer said that The more you conduct your investigation correctly, either these potential perpetrators, either they flee, or they try to do physical elimination. Some police reported being targeted more frequently as a result of doing better investigations. One police officer described that he had to move his family to another location as a result of the more thorough sexual assault case investigations he was now conducting. Among physicians, there is acknowledgement that the development and implementation of the medical certificate is producing more probative evidence for sexual assault cases. This

	validation is coming from all sectors, including from survivors, perpetrators, and their families. One physician described her personal involvement in a case where > There was a girl who was a rape survivor - she was only ten - and she was raped by a man who was 38. So, this girl who was raped by this man of 38 was alone home, and this man was their neighbor. Called the girl. The girl went to his home, and he abused the girl. The girl was sent to [redacted], a referral hospital. In [redacted], because this girl, ten years, she was bleeding in the vagina, [redacted] found that it was a case to refer to [redacted], which is the referral clinic for sexual aggression cases. We received the charge she was bleeding; there was a perforation in the vagina. We started repairing the girl because this was the first thing to do, otherwise her life would be in danger. After this, we completed the medical certificate. We sent to the police. The police continued investigations, up to the time when they arrested the man. They took him, transferred him from the small court in [redacted] to [redacted]...the process continued, and they sentenced-- this man was convicted. They condemned him to 15 years in prison. He's there in Bukavu Prison spending his days. There is also the perception among physicians that forensic photography, implemented since 2013, has been helpful in select cases. Unintended consequences include applying forensic investigative techniques to other exams, physicians testifying less in court as a result of improved understanding of the medical forensic certificate among individuals in the judicial sector, and impacts on personal security. One unintended consequence is that as more weight is being placed on the medical certificate, physicians feel that more attention is being placed on them by perpetrators (and families of perpetrators). One physician described a scenario where she > received a case of a woman who was brought by the police with a request, and they obliged me to do the examination and confer if the examination I did was consistent with sexual aggression. For this very case, the police officer arrested came back to tell me, "Doctor the perpetrator of this woman is arrested. He was caught and he's arrested, he's in jail. We're just waiting for your report, and we have had a lot of evidence that we are just waiting for

	your report to confer. If you say, 'Yes, it is consistent,' we condemn the person. If you say, 'No,' then the person will be released and everything is released in your hand." The family also came and say, "Doctor can't give another report different from confirming that they were sexual aggression." My examinations didn't show that they were really-- it was consistent with sexual aggression, but I was afraid. I was so afraid to give the report since these two parties were only waiting for me to say, "Consistent with," then I was afraid because I didn't know what would happen if I give them the true report - the result of the report I did. The increased attention across sectors being given to the medical certificate is perceived to place physicians at a higher risk. One physician described that since improving her forensic medical examination techniques, she is experiencing more threats. Some physicians describe the perception of more security when multiple people sign the medical certificate. Physicians explain that the feel at highest risk when the perpetrator is still free and has not yet been convicted or sentenced. This issue is heightened for physicians in remote, rural areas. PROGRAM RECORD DATA The program provided recommendations and technical assistance to implement reforms aimed at improving the multisectoral response to sexual assault in Kenya and the DRC. The status of institutional reforms receiving support from PHR were programmatically tracked on a monthly basis over a three-year period. In the DRC, one institutional reform was tracked as moving from leadership bought in (2016), to negotiated (2017), then in process of implementation (2018). In Kenya, two institutional reforms were tracked. The first moved from the leadership buying in (2017) to fully implemented (2018), and another reform beginning in 2018 moved from leadership bought in (2018) to implementation in process (2018).
Conclusions	By strategically targeting secondary beneficiary behaviors and institutional constraints that were limiting sexual violence survivors' access to justice, there is strong evidence that the program produced effects that resulted in positive changes in the lives of survivors of sexual violence. Secondary beneficiaries perceived that there were increased conviction rates occurring for perpetrators of sexual assault. Quantitative analyses confirmed that exposure to the PHR program was associated with an immediate increase in adjudication

	outcomes favoring the survivor. These outcomes reflect the orchestration of a complex multisectoral network that has improved forensic documentation and processing practices along with intersectoral articulation. Increased attention to documentation, as reported in secondary beneficiary interviews and as observed in medical and legal records, translated into survivors receiving more due diligence in investigation surrounding their cases. Results suggest that justice accessibility was more within reach for survivors in jurisdictions exposed to PHR programming activities than those without.

Table E1. Multiple-group interrupted time-series results derived from medical record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

	Thoroughness of medical forensic documentation outcomes				
Model terms	Body maps were completed	Survivor clothes were handed to the police	Samples were packed and issued	Genital examination of survivor complete	PEP first dose given
Time	0.00478	0.0109	-0.00275	-0.00333	-0.0109
(t for b1)	(1.45)	(1.44)	(-1.10)	(-1.33)	(-0.90)
Cohort	0.136**	0.219	-0.0278	0.0278	-0.141
(t for b4)	(2.72)	(1.68)	(-0.46)	(1.02)	(-0.72)
(Time)x(Cohort)	-0.00696	-0.00696	1.26e-17	-0.00362	0.00558
(t for b5)	(-1.78)	(-0.84)	(0.00)	(-1.05)	(0.43)
IP	-0.170	-0.274	-0.00725	-0.133	0.0721
(t for b2)	(-0.80)	(-1.16)	(-0.29)	(-0.65)	(0.37)
(Time)x(IP)	-0.00478	-0.0109	0.00275	0.00516	0.0238
(t for b3)	(-0.16)	(-0.35)	(1.10)	(0.18)	(0.87)
Treatment following intervention	0.211	0.177	0.0644	0.213	0.353
(t for b6)	(0.97)	(0.72)	(1.26)	(0.99)	(1.45)
Pre-post trend comparison	0.00696	0.0179	-0.00183	0.00362	-0.0633
(t for b7)	(0.24)	(0.57)	(-0.39)	(0.12)	(-1.95)
Constant	0.876***	0.667***	0.0733	0.997***	0.716***
(t for constant)	(18.08)	(5.63)	(1.64)	(50.04)	(3.97)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table E2. Multiple-group interrupted time-series results derived from medical record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

	Thoroughness of medical forensic documentation outcomes				
Model terms	ECP given	STI treatment given	DNA sample sent to laboratory	Part B of PRC form complete	Referrals provided following Part B
Time	-0.0112	0.0101	-0.00333	-0.0292*	-0.0335**
(t for b1)	(-1.17)	(1.19)	(-0.85)	(-2.35)	(-2.69)
Cohort	-0.146	-0.169	-0.0633	-0.253*	-0.114
(t for b4)	(-0.79)	(-0.93)	(-0.82)	(-2.01)	(-0.67)
(Time)x(Cohort)	0.0121	-0.0119	0.00551	0.0214	0.0257
(t for b5)	(1.05)	(-1.01)	(0.94)	(1.49)	(1.79)
IP	0.113	-0.251	0.0916	-0.305	-0.155
(t for b2)	(0.75)	(-1.22)	(0.91)	(-1.33)	(-0.77)
(Time)x(IP)	0.00757	-0.00648	0.00516	0.0182	0.0335*
(t for b3)	(0.42)	(-0.22)	(0.44)	(1.13)	(2.44)
Treatment following intervention	0.118	0.478	-0.160	0.582*	0.433
(t for b6)	(0.63)	(1.61)	(-1.39)	(2.27)	(1.86)
Pre-post trend comparison	-0.0387	0.0101	-0.00734	-0.0122	-0.0275
(t for b7)	(-1.66)	(0.26)	(-0.58)	(-0.68)	(-1.73)
Constant	0.525**	0.717***	0.0800	1.148***	1.010***
(t for constant)	(3.38)	(5.70)	(1.50)	(12.55)	(6.82)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table E3. Multiple-group interrupted time-series results derived from medical record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

	Thoroughness of medical forensic documentation outcomes				
Model terms	Assent of minor noted (if survivor was a minor)	Consent of parent/guardian noted (if survivor was a minor)	Received a pregnancy test (if female)	Received an HIV test	Received a VDRL test
Time	-0.00333	-1.05e-16	-0.00616	-0.00420	-0.00210
(t for b1)	(-1.12)	(.)	(-1.70)	(-0.68)	(-0.46)
Cohort	-0.100	-0.0478	-0.00500	0.0111	-0.0772
(t for b4)	(-1.64)	(-1.23)	(-0.09)	(0.15)	(-0.74)
(Time)x(Cohort)	0.0123	0.00899	-0.00319	-0.00942	-0.0108
(t for b5)	(1.84)	(1.50)	(-0.48)	(-1.18)	(-1.23)
IP	-0.0858	-0.0733	-0.102	0.0362	-0.162
(t for b2)	(-0.90)	(-0.79)	(-0.61)	(0.17)	(-0.91)
(Time)x(IP)	0.0821***	0.0678**	0.00799	-0.00679	-0.0162
(t for b3)	(4.22)	(3.18)	(0.34)	(-0.26)	(-0.46)
Treatment following intervention	0.163	0.151	0.243	0.263	0.479*
(t for b6)	(0.98)	(0.91)	(1.20)	(1.08)	(2.19)
Pre-post trend comparison	-0.0957***	-0.0813**	-0.00231	0.0186	0.0254
(t for b7)	(-3.81)	(-3.06)	(-0.09)	(0.65)	(0.67)
Constant	0.0522	9.85e-16	1.008***	0.951***	0.989***
(t for constant)	(1.11)	(.)	(34.90)	(18.72)	(20.10)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table E4. Multiple-group interrupted time-series results derived from medical record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

	Thoroughness of medical forensic documentation outcomes			
Model terms	Outer genital swab conducted	Anal swab conducted (if assault was anal)	High vaginal swab conducted (if assault was vaginal)	No data missing from swabs domain
Time	0.00928	-0.00370	-0.00312	-0.00710
(t for b1)	(1.11)	(-0.60)	(-0.52)	(-0.55)
Cohort	-0.0900	-0.0639	0.0150	-0.334
(t for b4)	(-0.94)	(-0.65)	(0.14)	(-1.54)
(Time)x(Cohort)	-0.0103	0.00978	-0.00674	0.0122
(t for b5)	(-1.21)	(1.21)	(-0.73)	(0.78)
IP	-0.221	0.0439	-0.445**	-0.134
(t for b2)	(-1.39)	(0.42)	(-3.12)	(-0.65)
(Time)x(IP)	-0.00744	0.0140	0.0403*	0.0272
(t for b3)	(-0.45)	(0.88)	(2.18)	(0.92)
Treatment following intervention	0.333	-0.216	0.816***	0.224
(t for b6)	(1.45)	(-1.64)	(4.43)	(0.75)
Pre-post trend comparison	0.00663	-0.0183	-0.0561*	-0.0488
(t for b7)	(0.23)	(-1.07)	(-2.61)	(-1.28)
Constant	0.116	0.105	0.876***	0.734***
(t for constant)	(1.26)	(1.36)	(11.49)	(3.98)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table E5. Multiple-group interrupted time-series results derived from legal record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

Model terms	Adjudication outcome / ruling favoring the survivor
Time	-0.00362
(t for b1)	(-0.77)
Cohort	0.125
(t for b4)	(1.06)
(Time)x(Cohort)	-0.00848
(t for b5)	(-1.16)
IP	-0.0450
(t for b2)	(-0.68)
(Time)x(IP)	0.00362
(t for b3)	(0.77)
Treatment following intervention	0.383**
(t for b6)	(2.77)
Pre-post trend comparison	-0.0231
(t for b7)	(-1.72)
Constant	0.132
(t for constant)	(1.90)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table E6. Multiple-group interrupted time-series results derived from legal record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

Thoroughness of medical forensic documentation outcomes *in the legal record*				
Model terms	Date and time of examination documented	Date and time of the incident documented	Number of perpetrators documented	Location of the incident recorded
Time	0.0152	0.0246	0.0217	0.0152
(t for b1)	(1.13)	(1.88)	(1.70)	(1.13)
Cohort	0.0300	0.188	0.188	0.0300
(t for b4)	(0.11)	(0.69)	(0.69)	(0.11)
(Time)x(Cohort)	-0.0243	-0.0336	-0.0309	-0.0243
(t for b5)	(-1.32)	(-1.85)	(-1.72)	(-1.32)
IP	-0.569*	-0.733*	-0.567*	-0.569*
(t for b2)	(-2.07)	(-2.64)	(-2.11)	(-2.07)
(Time)x(IP)	-0.0317	-0.0356	-0.0382	-0.0317
(t for b3)	(-0.94)	(-1.00)	(-1.14)	(-0.94)
Treatment following intervention	0.664	0.838*	0.662	0.664
(t for b6)	(1.90)	(2.39)	(1.92)	(1.90)
Pre-post trend comparison	0.0189	0.0226	0.0254	0.0189
(t for b7)	(0.40)	(0.47)	(0.55)	(0.40)
Constant	0.533*	0.363	0.375	0.533*
(t for constant)	(2.47)	(1.75)	(1.82)	(2.47)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table E7. Multiple-group interrupted time-series results derived from legal record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

Thoroughness of medical forensic documentation outcomes *in the legal record*				
Model terms	Chief complaint "observed" section filled out	Chief complaint "reported" section filled out	Section "circumstances surrounding the incident" fill out	Documentation of whether a condom was used
Time	0.00674	0.00152	0.0122	0.0104
(t for b1)	(0.47)	(0.10)	(0.89)	(0.78)
Cohort	0.360	0.0150	0.0367	-0.0100
(t for b4)	(1.35)	(0.05)	(0.13)	(-0.04)
(Time)x(Cohort)	-0.0259	-0.00674	-0.0213	-0.0127
(t for b5)	(-1.40)	(-0.33)	(-1.15)	(-0.71)
IP	-0.383	-0.169	-0.489	-0.162
(t for b2)	(-1.71)	(-0.61)	(-1.80)	(-0.62)
(Time)x(IP)	0.00974	-0.0180	-0.0287	-0.0489
(t for b3)	(0.40)	(-0.50)	(-0.84)	(-1.67)
Treatment following intervention	0.645	0.257	0.585	0.233
(t for b6)	(1.90)	(0.73)	(1.68)	(0.68)
Pre-post trend comparison	-0.0126	0.00124	0.0158	0.0457
(t for b7)	(-0.33)	(0.03)	(0.34)	(1.18)
Constant	0.277	0.462*	0.527*	0.297
(t for constant)	(1.39)	(2.16)	(2.45)	(1.63)

Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Table E8. Multiple-group interrupted time-series results derived from legal record reviews conducted over a 37-month period (October 2015-October 2018) at intervention (Nakuru) and control (Kibera) sites in Kenya

	Thoroughness of medical forensic documentation outcomes *in the legal record*		
Model terms	Documentation of whether incident reported to the police	Survivor attended a health facility before this one	Body maps were completed
Time	0.0157	0.0233	0.0152
(t for b1)	(1.16)	(1.49)	(1.13)
Cohort	0.0767	0.393	0.0300
(t for b4)	(0.27)	(1.46)	(0.11)
(Time)x(Cohort)	-0.0248	-0.0324	-0.0243
(t for b5)	(-1.35)	(-1.62)	(-1.32)
IP	-0.533	-0.399	-0.569*
(t for b2)	(-1.97)	(-1.31)	(-2.07)
(Time)x(IP)	-0.0321	-0.0397	-0.0317
(t for b3)	(-0.95)	(-1.12)	(-0.94)
Treatment following intervention	0.628	0.494	0.664
(t for b6)	(1.82)	(1.32)	(1.90)
Pre-post trend comparison	0.0193	0.0269	0.0189
(t for b7)	(0.41)	(0.56)	(0.40)
Constant	0.487*	0.170	0.533*
(t for constant)	(2.27)	(0.85)	(2.47)

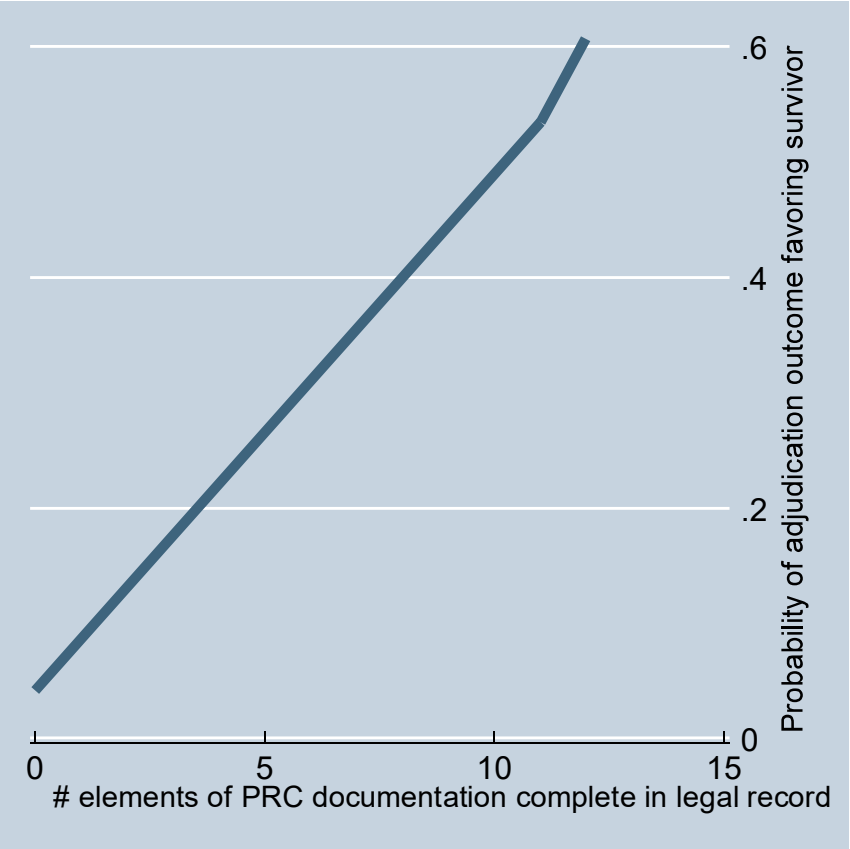
Abbreviations and symbols:

IP = Intervention period, Cohort=1 for Nakuru, 0 for Kibera

(t statistic in parentheses)

**p<0.05, **p<0.01, ***p<0.001*

Figure E1. Relationship between adjudication outcomes favoring survivor of sexual assault and each additional element of PRC documentation examined that was complete in the medical record appearing in Nakuru legal records during the post-intervention period (n=30)*



**Predicted probability values are derived from a logistic regression*

3.6 Knowledge generation

Evaluation Criteria	Knowledge generation
Evaluation Question 6	To what extent has the project generated knowledge, promising or emerging practices in the field of EVAW/G that should be documented and shared with other practitioners?
Response to the evaluation question with analysis of key findings by the evaluation team	The PHR program disseminated evidence-based knowledge in the forms of training and capacity building, and published or has academic papers in the development pipeline for publication and dissemination. While the PHR trainings focuses on a wide-range of advanced topics ranging from medical forensic examinations to pediatric examinations and forensic photography, key lessons from trainings were found to be disseminated by trainees following trainings, namely occurring between colleagues (secondary beneficiaries) in an occupational setting. Sometimes these lessons were structured in meetings, or transmitted through one-on-one mentoring sessions and/or technical assistance provided to colleagues in practice. The information that participants described disseminating indicates local knowledge gaps where PHR's knowledge generation was perceived to be most helpful by secondary beneficiaries. *Kenya* In Kenya, physicians paid particular attention to PHR's andragogic technique of using standardized patients and case study models to transmit best practices. Pediatric examination topics that were deemed of particular interest and use included techniques for taking the child survivor's narrative from a child, and rapport building with child survivors. Interviews about knowledge generated by PHR highlighted gaps in Kenyan medical education regarding the management and care of sexual assault survivors who present to healthcare facilities, as well as gaps in training regarding forensic medical examinations. In the law enforcement environment, the collection of evidence/exhibits, medical evidence collection and transfer, and laminated curriculum companions provided by PHR were deemed useful. *DRC* In the DRC, physicians described that general knowledge transmitted by the program regarding the collection of medical forensic evidence and obtaining the consent of the survivor (particularly minors) was useful. Numerous participants focused on knowledge gained and transmitted to others regarding forensic photography. Legal sector participants focused on the utility of the medical lexicon, not only in their own practice, but in training investigating police officers on best practices.

	Peer-reviewed publications Finally, during the course of the project period, the Sexual Violence program published four academic manuscripts that were published in peer reviewed public health journals. Further, the program began undertaking research on gaps, challenges and barriers in state prevention of and effective responses to sexual violence occurring during election-related violence in Kenya, in partnership with UN Women and the Office of the UN High Commissioner for Human Rights.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	The evidence gathered to address the knowledge generation evaluation criteria was both qualitative and quantitative in nature. Data were derived from the experiences and perspectives of healthcare, law enforcement, and legal sector trainees regarding specific cases where PHR initiatives affected the lives of women and girls during the course of program implementation, and data were also derived from the program record monitoring spreadsheet and associated PHR publications. For the semistructured interviews, interviewees were asked what they perceived to be the most important lessons learned that should be shared among other professionals. Trainees were able to articulate what information they felt was the most important and also what challenges to knowledge generation they perceived to be the most pressing. Results are presented below by country (Kenya and DRC). *Kenya* Most respondents indicated that they were able to share PHR information with their respective colleagues through informal conversations and semi-formal "round table" discussions. For example, in one medical facility, it was a matter of occupational culture that when anyone attended a training they would report important information back to their colleagues. Medical professionals described that others were often interested to learn how others in their sector are working in resource-restricted settings. As one nurse practitioner said, "We are always interested in what other doctors and nurses do when they have the same challenges as us. What do they do when there is no PRC form? What do they do when the police are being rude?" In this setting, a PHR trainee shared information with his colleagues regarding evidence preservation and the importance of cooperating with police when a survivor was presented. Specific lessons derived from PHR training within the medical sector focused on the andragogic technique of using standardized patients and case study models to transmit best practices to other

	colleagues. In colleague meetings and/or sessions with medical students, PHR trainees focused on disseminating knowledge focused on pediatric issues in sexual assault examinations, including taking the survivor's narrative from a child, and rapport building with child survivors. Interviewees described that best practices derived from training and distributed to others who did not attend training. Talking about knowledge dissemination in this context produced discussions regarding a gap in Kenyan medical student practicum/experience regarding managing the care and treatment of sexual assault survivors who present to healthcare facilities, as well as general gaps in forensic medical examination training in Kenyan medical schools. There have also been appreciable instances of dissemination of knowledge derived from PHR trainings among law enforcement officials. A PHR-trained police officer said that he shares PHR training information with other officers in a one-on-one format, often in the form of "on-the-job training" while at actual crime scenes. The benefit of such training has been noted by legal professionals: What we have been witnessing is that the police who have been trained have been disseminating the information to the other officers. It has actually been of great advantage because we have officers who are able to know the kind of care and preservation to accord in dispatch of the forensic evidence. In the law enforcement environment, this included PHR-trained police officers described accompanying untrained officers in the field to collect evidence/exhibits, by directly showing colleagues how to work with traumatized survivors, and by focusing on medical evidence collection and transfer practices. To describe concepts to colleagues, laminated curriculum companions distributed by the program and notes from previous PHR trainings were used to provide visuals/examples and to clarify concepts on a case-by-case basis. While personnel transfers in and out of a post are issues presumed to mitigate the impact effect of PHR's program, we found evidence of PHR-trained police officers who were transferred to a new post and who, following transfer, provided one-on-one mentoring to untrained colleagues (on a case-by-case basis) on best practices as untrained colleagues' sexual assault investigations moved forward. There were other forms of knowledge transfer described, including social workers training networks of survivors in the community (members of community-based organizations) to help navigate new survivors through the medico-legal web (or training survivors now working as volunteers to help navigate new cases and to increase case processing efficiency).

	Police officers frequently described how they would be more successful in sharing the information with other officers if there was a greater level of "buy-in and commitment" among higher-ranking officers. This would make it more likely that lower ranking officers would be willing to listen to, or be advised by, other officers or legal professionals on issues of evidence collection. Too often, a PHR-trained officer explained how new officers are only willing to follow the directions or advice of their superiors as opposed to other equally-ranked officers. Similarly, some police officers were described as being uninterested in learning the specifics of sexual violence investigation because either it was "only for the gender desk officers" to worry about, or that "sexual violence is not as important as other problems." Variable levels of discretionary support throughout vertical chain of command structures remains an ongoing impediment to the transmission of knowledge within law enforcement. *DRC* Physicians reported sharing lessons learned from the PHR training with other physicians. Most of this information was described as being transmitted during departmental training meetings. The key information that physicians described sharing is with regard to how to collect medical forensic evidence, but some reported on training others to obtain the consent of the survivor, including obtaining consent in cases with minors. In other cases, physicians have instructed their untrained colleagues to begin taking forensic photography for all sexual assault cases. The information transmission periods are short, however, sometimes lasting less than an hour. Most of this information is transmitted during departmental training meetings. There is the desire for additional medical personnel to be trained, including head nurses at healthcare facilities. Police officers described how, following the PHR training, they influenced other officers to arrive at crime scenes and conduct more thorough crime scene investigations. One police officer described holding mini training sessions with subordinates following the PHR training in order to improve investigative practices. There were multiple examples of information sharing among legal sector participants, including legal sector participants sharing lessons with law enforcement. Individuals from the legal sector described sharing lessons learned from the PHR training to MONUSCO personnel during investigations. Another magistrate described sharing PHR training materials, particularly the medical lexicon, with his colleagues following the training. As it concerns

	sharing lessons learned from the PHR training with law enforcement, one magistrate took the time to speak with the judicial police about providing more holistic care to victim following PHR training. Another magistrate trained the judicial police in investigations following the PHR training so that more cases would result in adjudication outcomes and not dismissals. This magistrate focused particularly on evidence collection, including how to analyze the survivor's narrative in order to take into account contextual information that might have been provided by the survivor. One trainee made the comment that it is difficult to share information provided by PHR because the information is so technical and scientific. Participants wanted more opportunities for inter-regional lesson sharing between Bukavu, Kinshasa, and other areas. Another participant explained that it would be important for individuals from other sectors to observe an investigation being done by another sector (e.g. police officers observing a forensic medical exam, or physicians observing a crime scene investigation conducted by law enforcement personnel). Several legal sector participants were interested in learning from judges and lawyers' experiences with sexual assault cases in other jurisdictions outside of the DRC. There is a great desire to move key lessons concerning evidence collection, storage, and transfer to the interior (more rural parts) of the country. *Peer-reviewed publications* During the course of the program, the Sexual Violence program at PHR generated knowledge that was circulated in academic discourse by publishing four academic manuscripts in peer-reviewed outlets: The Journal of Interpersonal Violence, the Angle Journal, Global Health Science and Practice, and Genocide Studies and Prevention. The references for those publications are: 1) Ferdowsian H, Kelly S, Burner M, Anastario M, Gohlke G, Mishori R, McHale T & Naimer K. (2016). Attitudes Toward Sexual Violence Survivors: Differences Across Sectors in Kenya and the Democratic Republic of the Congo. J Interpers Violence. Mar 27. doi: 10.1177/0886260516639257. 2) Ferdowsian, H., Mishori, R., & Naimer, K. (2016, Jan). Prosecuting Sexual Violence in Conflict: A medical approach. Angle Journal. Retrieved from http://anglejournal.com/article/2015-12-clinicians-in-the-prosecution-of-conflict-related-sexual-

	violence/ 3) Mishori R, Anastario M, Naimer K, Varanasi S, Ferdowsian H, Abel D, Chugh K (2017). mJustice: Preliminary Development of a Mobile App for Medical-Forensic Documentation of Sexual Violence in Low-Resource Environments and Conflict Zones. Glob Health Sci Pract. Mar 28;5(1):138-151. doi: 10.9745/GHSP-D-16-00233. Print 2017 Mar 24 4) Naimer K, Brown W, and Mishori R (2017). MediCapt in the Democratic Republic of the Congo: The Design, Development, and Deployment of Mobile Technology to Document Forensic Evidence of Sexual Violence. Genocide Studies and Prevention. Volume 11, Issue 1, Article 6.
Conclusions	The PHR program generated and disseminated knowledge regarding emerging best practices and lessons learned in the field through a variety of wide-ranging modalities. The program trained professionals on best practices in sexual assault examination and made resources available such that best practices surrounding evidence collection and transfer could be implemented in resource constrained settings where prior knowledge gaps existed and were described by secondary beneficiaries of the program. Knowledge shared by the program by secondary beneficiaries with their colleagues highlighted gaps in local higher education that secondary beneficiaries are aiming to change. Further, the program developed and shared findings regarding mJustice, mobile technology development, secondary beneficiary attitudes, and prosecuting sexual violence cases with the broader scientific and programming community through the publication of four peer reviewed manuscripts in internationally recognized journals.

3.7 Gender equality and human rights

Evaluation Criteria	Gender equality and human rights
Evaluation Question 7	Cross-cutting criteria: the evaluation should consider the extent to which human rights based and gender responsive approaches have been incorporated throughout the project and to what extent.
Response to the evaluation question with analysis of key findings by the evaluation team	As part of the state's due diligence in investigating crimes of sexual assault, there remain serious structural gaps resulting in impediments to survivors' rights that would otherwise increase accessibility to Justice. For an effective legal outcome, probative evidence is needed. If evidence is being systematically collected in a poor manner, and if there are structural impediments to the production of forms issued by the state that should otherwise be adequately populated when a survivor reports an act of sexual violence, both the rights of the survivor and their accessibility to justice is hampered. *Focusing on human rights* Through myriad local activities in the DRC and Kenya (such as advocating for P3 form waivers or developing a forensic certificate), multisectoral network members (whose networking was facilitated in part by PHR) participated in advocacy and institutional change efforts that aimed to increase survivors' access to documentation in a feasible manner, taking into account local structural and institutional constraints that mitigate this accessibility. *Sex disaggregation* When disaggregated by sex, quantitative changes in medical and legal records show appreciable improvements for male survivors. This is not to say that male survivors are receiving better treatment than female survivors, but rather, that gender biases surrounding reporting and attention provided to survivors are reducing as a result of exposure to PHR-programming such that secondary beneficiaries are providing survivors with more adequate documentation and investigation services. While control cases moved in negative directions across many outcomes for female cases (possibly reflecting national strikes), intervention cases remained relatively stable, suggesting a possible resilience mechanism among PHR-exposed sites. *Summary* The program's focus on documentation moved beyond focusing on individual behavior change and was referenced by multiple secondary beneficiaries as underlying local efforts to make

	institutional and structural changes that reinforce the rights of survivors to receive due diligence in investigations of sexual assault.
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	QUANTITATIVE EVIDENCE FROM RECORD REVIEWS Based on key findings from the effectiveness and impact sections of this report, we further disaggregated select medical and legal record review outcomes by gender to examine basic patterns relative to the program exposure period. Given the small number of male cases, we could not conduct the interrupted time series analysis by gender. Thus, we examined basic distributions relative to the period of program exposure, where possible. Selected medical record outcomes examined included whether there was documentation of the incident being reported to the police, documentation of informed consent, part B of the PRC form being complete, and whether a VDRL test was conducted. Select legal record outcomes examined included the number of select PRC form elements completed within legal records, the date and time of the incident being document in medical records, and adjudication outcomes favoring the survivor. *Medical record outcomes disaggregated by sex (Table G1)* Within male cases, there were appreciable increases in all medical record outcomes examined (within the intervention condition), with all male cases increasing to having 100% documentation and completeness outcomes on all elements examined. Female cases in the intervention condition remained stable on documentation of whether the incident was reported to the police, but also showed relative increases when compared with the control condition on documentation of informed consent, part B of the PRC form being complete, and the completion of a VDRL test. A visual representation of these relative changes associated with the PHR-program exposure condition are also shown in Figure G1. *Legal record outcomes disaggregated by sex (Table G2)* In comparison to control cases, male cases showed appreciable increases in all legal record outcomes examined. Female cases showed relative stability in comparison to outcomes notably moving in the negative direction for the control condition. These control condition outcomes could reflect a number of factors that occurred in Kenya during the PHR program (including a strike of medical workers), and thus the relative stability of the female findings compared with the control condition could be interpreted as a type of “buffer” to the otherwise negative effects observed.

QUALITATIVE EVIDENCE FROM SEMISTRUCTURED INTERVIEW DATA

As part of its programmatic activities, PHR supported meetings between and provided technical assistance to multisectoral networks as they identified and acted upon advocacy and institutional change efforts. The foci of network members not only vary by country, but by region within a country. The issues identified by network members correspond to their strategic actions to change laws and/or institution in the service of the rights of survivors of sexual assault. The myriad forms in which these changes are implemented are best captured by interviews with network members who have been in the process of implementing these changes in concordance with support from the PHR program. Below, several of these initiatives aimed at supporting the rights of sexual assault survivors to better access Justice are described.

Kenya

While various forms of network-based advocacy efforts in the service of the rights of survivors of sexual assault were described, the three most narrated advocacy processes involved networks located in Nairobi, Naivasha, and Nakuru. They are summarized below.

It appeared that there were multiple network initiatives in Nairobi. Members of one of the Nairobi-based networks described that network members chose to focus advocacy activities on documentation issues that arise in sexual assault cases. The underlying issue was that sexual assault survivors are expected to have PRC and P3 form documentation in order to move forward with legal processes, which can become burdensome and prohibitive for survivors accessing the justice system. One network participant described that

> We were recommending that when the doctor fills that information in the hospital, he should not now then take again that information back to the government. There's the government doctor who signed and who is supposed to fill the P3 form. You realize that even in some cases, especially in Kenya, when there's a case of gender-based violence and the case is taken to Nairobi Women's Hospital, there are doctors there who examine the survivor and write the report in the PRC form. Then you realize that the same, same information, again, you are supposed to take to the government doctor for him again to fill P3 form for them. So, we wanted at least to have one

	form. If the patient is given a PRC form, they should not again go for P3 form. Because the process is very tedious and sometimes people give up on the process. These two separate forms pertaining to the same sexual assault incident are typically filled out by different healthcare providers located in different locations. Network members also described how some survivors lose their cases in court due to missing signatures on standardized forms as well as documentation domain issues inherent to the form itself. A first step identified in addressing sexual assault documentation issues that reduce survivor-centeredness was to work on getting the government to adopt a P3-waiver for sexual assault survivors. Network members described having achieved a first success in increasing the number of doctors available to fill out and sign P3 forms in order to reduce patient volumes/wait periods for P3 forms. Network members describe the ultimate goal as being the elimination of the P3 requirement if the PRC form is properly filled out. In order to achieve changes, members of the network describe working directly with the National Gender and Equality Commission (NGEC) to more effectively lobby the government on documentation issues. Members described meeting with NGEC on a monthly basis. Network members describe that working with the government to achieve these changes is slow and tedious. The Naivasha network also described working on documentation issues that pertain to the PRC/P3 form requirements. Similar to the Nairobi network documentation issues described above, members of the Naivasha network described wanting the PRC form to be the primary form required from survivors to move forward with legal proceedings, and to eliminate the need for P3 forms in sexual assault cases with PRC form documentation. Naivasha network members described that one of the current issues they are experiencing regarding documentation is that nurse signatures on the PRC form are being contested in court. Members of the Naivasha network described wanting a centralized database/portal to track case processing stages. Members described that they needed to lobby elected members of government to better sort out documentation issues that are occurring, but they say that new legislators claim that they do not have funds to push for new legislation. Members of the Naivasha network described wanting additional assistance from PHR in lobbying county executive committees in order to increase budgets allocated to gender-related issues. One Naivasha network member described how Right now, what we are doing, within the county government, we have what we call county executive committees. These guys are the ones who decide--

these are the guys who would decide whether they give out the money. They make decisions. They make policies…So it's a matter, for us, to look for resources, look for a way we can reach these guys, and talk to them, and show them how it is doable, and how it is very helpful, and within their budgets because they have budgets for gender, make sure they use it for this purpose. But I cannot do it alone…I can only do it as a network.

In Nakuru, network members described being part of the Children's Court Users' Committee (CUC), with their goal being to advance the best interest of the child. The Nakuru Law Courts are described as handling many children's cases, and network members have identified that issues arise in cases where both the alleged perpetrator and victim are both children. Members described a lack of child-centeredness particularly in the law enforcement and justice sectors, including current approaches that over-issue the punitive/retributive aspects of justice regarding children. To achieve changes, the Children's CUC presents legal challenges to the National Committee on the Administration of Justice (NCAJ). One network member described how

> There is a bill in parliament that proposed changes to the law, whereby we made a proposal that we should look at the young offenders, not quite children, the young offenders differently. For instance, an 18-year old boy defiles a 17-year old girl, which in basic, these are more or less age-mates, but the law says one is a child, one is an adult, such that if we have such a person, an 18-year old, who is probably a schoolboy before us and the act was not forcefully done, that fellow should be treated differently from a 50-year old who sleeps with a 17-year old. That's what we thought. The other aspect that I know has been proposed for amendment is the issues running around where the offender and the victim are both children. Most of the time what happens is that it's the boy who is taken before the court. And remember, children are supposed to be equal under our law. So now there is that question mark. Why the boy, and why not the girl? So, we made a proposal and I'm aware it is being addressed that one of the proposals we made was that these young offenders, the children… 16 and 17-year old boy and girl, let them not just take the boy to court. We should go through another procedure. We have a procedure

currently where children come, those who are under threats, those who need care and protection. We thought perhaps these two should be taken through care and protection process. We bring in the parents, and there should be a procedure, yeah, rather than charging the 17-year old boy, who is a boyfriend to the girl, and then the girl comes to court to be the witness.

Network members also described using the network to disseminate information to other network members. Various goals of the Children's CUC regarded sexual assault crimes, but it is unclear where the network stands with regard to implementation on advocating for changes. Members stated that they have broad goals of adjusting the law to reflect age differences in perpetrators/victims (wanting to be able to distinguish consensual peer contacts from statutory rape and sexual assault), wanting to conduct prison reforms to make incarceration less punitive for child perpetrators, and wanting to use VideoLink for children's cases in the justice sector (also commenting that VideoLink technology is too expensive). Children's CUC members describe that the number of transfers occurring in their networks diminishes their advocacy capacity.

DRC

When asked about whether the networks had policy-related objectives, or if they were working toward any sort of regulatory change, participants provided various responses. A member of the North Kivu network indicated that national-level policy could not be the focus of their activities because those changes had to happen at the national legislative level and the eastern region of DRC was isolated from those processes. One network member poignantly stated, "The Congolese state does not exist in the east regions." In a similar manner, a magistrate said the national government is not responsive when it comes to gender-based violence initiatives and thus, "we are left dependent on the assistance of organizations like PHR and others who will provide the funding and material support for these activities. A policy focus is outside of our capacity." It was commonly stated by interviewees that this high-level advocacy is best provided by organizations like PHR who have national and international influence.

Another network member, in response to a direct question about policy and regulatory reforms that the network could be working on, explained that processes at the national and ministerial levels are not accessible to sexual violence stakeholders at local levels. As an example, in a discussion regarding the forensic

certificate and whether or not it was feasible for the network to advocate for its adoption at the national level, one secondary beneficiary explained:

> No. Our network cannot work on it. It's a high level. You have to work in high [ministerial] level to introduce it. We are already okay with [using the certificate], but it's the judicial procedure does not allow it. That's why even we work on it, but for us it's like double work. Yes. It's better to work high and then they can accept it, and then for us it will be easy to follow.

A member of the South Kivu network responded to the question about policy-focused objectives by stating that the referral process maintained by his network is a policy change:

> There is a policy that changed. It is collaboration. Before it, I provide medical care. I finish and she can go. And it is now in our mind that when I receive a survivor, I give them medical help but I interest the survivor about seeing the police so that investigation will start or bring her to the legal part and other people so that she can also be healed judicially. And this never happened before. And the same way I said about our [hospital], if the police receives a woman who just comes because she wants the perpetrator to be arrested or justice to be done that the police officer refers her here because he wonders what if the perpetrator was infected, had a sexually transmitted disease. Brings her here so that she could have the medical package. The same with the judicial. They also refer people here. So, this collaboration is I think one of the few policies we've changed in our minds.

Given the reported efficiencies in case processing described by network members, more attention was given to the ways in which regional networks can positively influence the lives of sexual assault survivors. Generally, network members discussed their activities as being centered around survivors and survivors' access to "justice," "judicial healing," and "satisfaction." When asked how network activities translated into better outcomes for individual survivors of sexual violence, network members typically described specific cases where there was a successful outcome or newly developed relationship with other sectors. In reference to a specific case, one network member stated:

> I think that the typical case is the Kavumu case. That was a big achievement of the network, and everybody was involved. Of course, I was not

	involved directly because it was military court, and I work for civilian courts. I saw everybody bringing his or her piece of expertise. I saw judicial police officers. I saw Panzi lawyers. I saw doctors. I saw everybody coming in, bringing-- and it was very important, mostly because crimes happened a bit longer ago than now, and putting the connection from the causes and the effects, that was the biggest thing which was done, that they happened to bring all the evidence of-- though rape happened sometime before the time of judgment. In a similar example, but from the other network, a magistrate observed: So, the doctors who come in the chain providing medication, psychologists who come with the psychological care, police officers and judges who come with their legal assistance bring it to the court until there is judgment. So, the survivor feels at ease and finds satisfaction to all her preoccupations. The two examples described above were common statements made by interviewees who saw the network's (and each person's role within it) to always have the outcome in mind when conducting their work. One interviewee described a network meeting where they discussed a case that had been recently dismissed because of evidentiary issues. The network, as a group, went through the case step-by-step to identify where there were the gaps in the evidence collection. They concluded that the forensic certificate had not been properly completed and investigated further as to why. Despite the many challenges associated with high-level changes in the DRC, several network members participated in the development of (and push for national adoption of) the forensic certificate, which throughout this report has been perceived as one of the most probative elements in a sexual assault case in the DRC, where the collection and processing of DNA tests are relatively infeasible. As such, attention provided to the development and implementation of the forensic certificate is likely one of the more potent effects focused on the rights of sexual violence survivors.
Conclusions	By focusing on survivors' access to adequate documentation as part of sexual assault investigations, secondary beneficiaries made efforts (with support from the PHR program) to rectify local structural and institutional impediments to adequate documentation. These structural changes affected the rights of survivors to receive due diligence in investigations of sexual assault. Sex disaggregated analyses of key record outcomes suggest a reduction in gender biases in documentation and thoroughness of investigation, even in cases where exogenous factors (such as personnel strikes) may

	impact survivors' ability to obtain adequate investigations. The program's focus on documentation was strategically behavioral (through training and capacity building) and structural (through network building and institutional capacity building). By strategically focusing on secondary beneficiaries, the program reinforced local actions with less gender biases in support of the rights of survivors to receive due diligence in investigations of sexual assault.

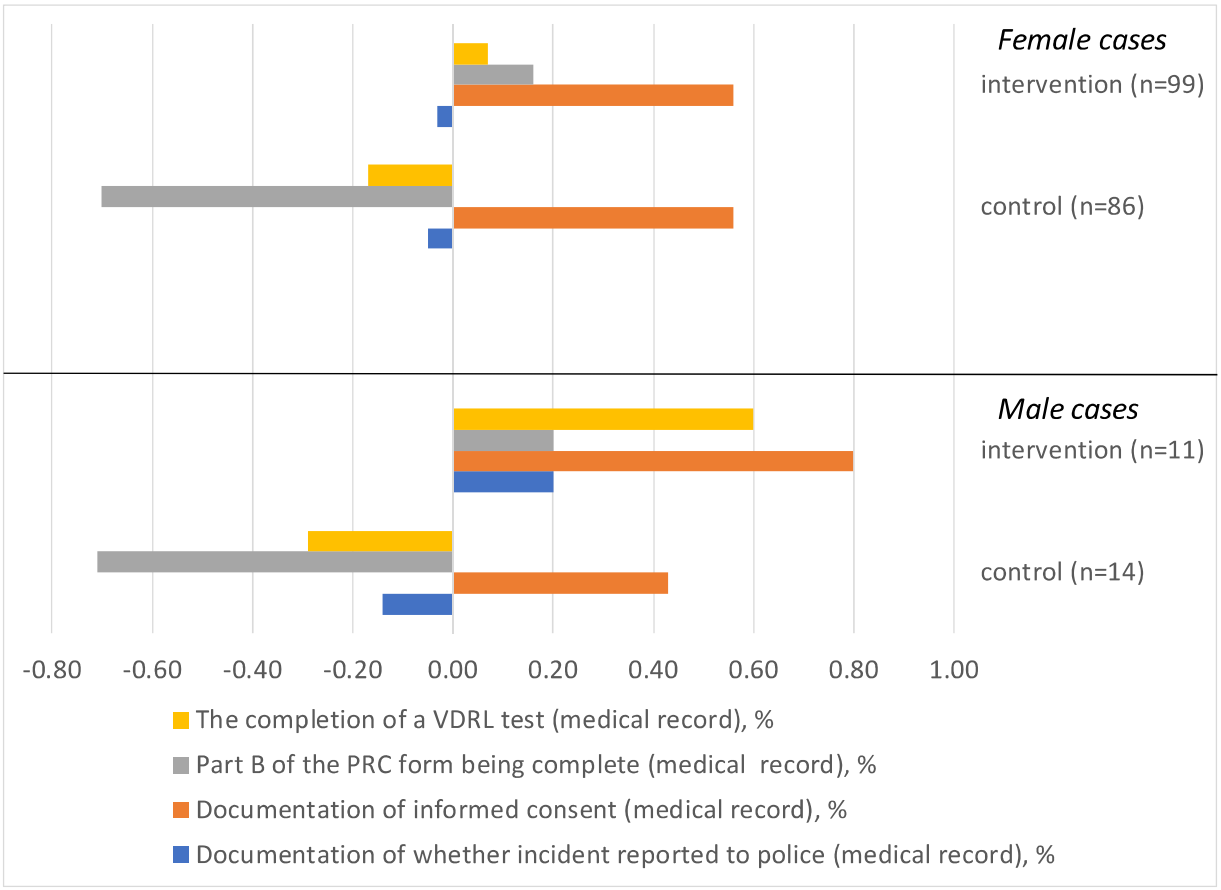
Table G1. Select medical record outcomes disaggregated by gender of the survivor

Record item		Male (n=25)		Female (n=185)	
		control (n=14)	*intervention (n=11)*	*control (n=86)*	*intervention (n=99)*
Documentation of incident reported to police (medical record), %	*pre*	1.00	0.80	0.93	0.95
	post	0.86	1.00	0.88	0.92
Documentation of informed consent (medical record), %	*pre*	0.00	0.20	0.00	0.06
	post	0.43	1.00	0.56	0.62
Part B of the PRC form being complete (medical record), %	*pre*	0.71	0.80	0.82	0.81
	post	0.00	1.00	0.12	0.97
The completion of a VDRL test (medical record), %	*pre*	1.00	0.40	0.97	0.82
	post	0.71	1.00	0.80	0.89

Table G2. Select legal record outcomes disaggregated by gender of the survivor

Record item		Male (n=17)		Female (n=193)	
		control (n=8)	*intervention (n=9)*	*control (n=102)*	*intervention (n=91)*
# PRC elements complete in legal record, *mean*	*pre*	0.00	5.66	3.32	2.31
	post	0.00	8.00	0.89	1.30
Date and time of incident being documented in medical record within legal record, %	*pre*	0.00	0.50	0.32	0.19
	post	0.00	0.67	0.05	0.11
Adjudication outcomes favoring survivor, %	*pre*	0.17	0.17	0.08	0.11
	post	0.00	0.33	0.00	0.11

Figure G1. Medical record post-intervention period changes,* disaggregated by gender of the survivor



**changes reflect the pre-intervention value subtracted from the post-intervention value*

4. Evaluation conclusions

Evaluation Criteria	Conclusions
Overall	There is evidence to support that the program was able to achieve key changes in support of its goal to deepen and expand cross-sector responses to sexual violence in ways that improve medical and psychological documentation of sexual assault, strengthen police investigations, and to increase the likelihood of justice and reparations for women and girl survivors of sexual violence. It is particularly notable that perceptions of and quantitative evidence of adjudication outcomes favoring the survivor increased in the period immediately following the intervention, and that the quantity of medical evidence in the legal record (a key focus of PHR's programming) was associated with an increased likelihood of an adjudication outcome favoring the survivor. The evidence used to examine this impact was based on extensive qualitative interviews with secondary beneficiaries, systematic medical and legal record reviews, and a review of existing program monitoring data.
Effectiveness	As reflected in medical and legal records where services have been provided to survivors of sexual assault, PHR program exposure was associated with increases in medical and legal documentation quality that depend on multisectoral coordination. This coordination is dependent upon the implementation of best practices in complex local contexts, and participants from medical, legal, and law enforcement sectors provided specific examples of how PHR program activities changed their everyday occupational behaviors to achieve such outcomes in the DRC and Kenya. Participants also described programmatic efforts to support advocacy efforts that made documentation less cumbersome and more accessible for survivors in both countries. These changes are reflected the records/services provided to sexual assault survivors.
Relevance	The extent to which the PHR program's achieved results were relevant to the needs of women and girls (including all survivors of sexual assault) is evident in the program's unique attention to the provision of survivor-centered care by service providers across sectors in both countries, where increased programmatic attention was provided to child sexual assault cases, rural survivors and mass-crimes investigations. These programmatic results helped secondary beneficiaries (service providers) implement investigations that were more relevant to and centered on survivors' unique needs that varied according to the location in which secondary beneficiaries were operating, thereby improving justice sector accessibility among survivors of sexual assault.
Efficiency	Beyond programmatic spending associated with patient pathway and service assessments at health centers, the generation and delivery of recommendation documents provided to health centers, completed plans for institutions to integrate forensic training material into curriculums, protocols, practices, and in-service and pre-service trainings, and the

	generation of signed agreements between PHR and selected institutions concerning details of a joint plan, the program developed and implemented trainer-of-trainer and mentoring models that by the third spending period illustrated efficiency in the number of secondary beneficiaries reached. Qualitative evidence shows that while dose of the program's effect was attenuated within these numbers, various models of disseminating best practices occurred across sectors and countries. This particular efficiency analysis focused on building capacity and disseminating knowledge, and the program exhibited efficiencies by month 18 of program activities.
Sustainability	From the outset, the PHR program worked in two countries with resource and structural constraints that otherwise mitigate individual behavioral changes that any program could achieve within secondary beneficiaries. The program intervened in these complex local contexts while simultaneously continuing training and trainer of trainer activities that carry their own effects. Trainees described improvements in attitudes toward survivors of sexual assault following the program, which also affected institutional support for local sexual violence programming. Record review results reinforced that particular medical documentation practices and legal documentation practices were key outcomes that were in the process of being improved on an "upward" or "resistance to otherwise negative effects" trajectory following the intervention period, but temporal variation in outcomes in the control site and country-wide resource restrictions may simultaneously produce exaggerated effects for this particular analysis. Taken together, the quantitative and qualitative findings suggest that the program's impact on forensic documentation practices that appear in records reflect sustained changes in secondary beneficiary behavior that may be disseminated to other secondary beneficiaries with diminishing doses through a training of trainer model, with modest evidence of institutional or structural change that may support positive behavioral changes throughout the future.
Impact	By strategically targeting secondary beneficiary behaviors and institutional constraints that were limiting sexual violence survivors' accessibility to Justice, there is strong evidence that the program produced effects that resulted in positive changes in the lives of survivors of sexual violence. Secondary beneficiaries perceived that there were increased conviction rates occurring for perpetrators of sexual assault. Quantitative analyses confirmed that exposure to the PHR program was associated with an immediate increase in adjudication outcomes favoring the survivor. These outcomes reflect the orchestration of a complex multisectoral network that has improved forensic documentation and processing practices along with intersectoral articulation. Increased attention to documentation, as reported in secondary beneficiary interviews and as observed in medical and legal records, translated into survivors receiving more due diligence in investigation surrounding their cases. Results

	suggest that justice accessibility was more within reach for survivors in jurisdictions exposed to PHR programming activities than those without.
Knowledge Generation	The PHR program generated and disseminated knowledge regarding emerging best practices and lessons learned in the field through a variety of wide-ranging modalities. The program trained professionals on best practices in sexual assault examination and made resources available such that best practices surrounding evidence collection and transfer could be implemented in resource constrained settings where prior knowledge gaps existed and were described by secondary beneficiaries of the program. Knowledge shared by the program by secondary beneficiaries with their colleagues highlighted gaps in local higher education that secondary beneficiaries are aiming to change. Further, the program developed and shared findings regarding mJustice, mobile technology development, secondary beneficiary attitudes, and prosecuting sexual violence cases with the broader scientific and programming community through the publication of four peer reviewed manuscripts in internationally recognized journals.
Gender Equality and Human Rights	By focusing on survivors' access to adequate documentation as part of sexual assault investigations, secondary beneficiaries made efforts (with support from the PHR program) to rectify local structural and institutional impediments to adequate documentation. These structural changes affected the rights of survivors to receive due diligence in investigations of sexual assault. Sex disaggregated analyses of key record outcomes suggest a reduction in gender biases in documentation and thoroughness of investigation, even in cases where exogenous factors (such as personnel strikes) may impact survivors' ability to obtain adequate investigations. The program's focus on documentation was strategically behavioral (through training and capacity building) and structural (through network building and institutional capacity building). By strategically focusing on secondary beneficiaries, the program reinforced local actions with less gender biases in support of the rights of survivors to receive due diligence in investigations of sexual assault.
Others (if any)	N/A

5. Evaluation recommendations

Evaluation Criteria	**Recommendations**	**Relevant Stakeholders** (Recommendation made to whom)	**Suggested timeline** (if relevant)
Overall	To publish the legal record review findings regarding adjudication outcomes and role of medical evidence in adjudication outcomes examined in the peer reviewed literature	PHR program staff	1-2 years following impact evaluation
Effectiveness	None	--	--
Relevance	None	--	--
Efficiency	None	--	--
Sustainability	That the program make core training materials available to medical and nursing school faculty responsible for forensic training	PHR program staff, Ministries of Education in Kenya and the DRC, local medical and nursing schools in Kenya and the DRC, UNTF	2-3 years
Impact	None	--	--
Knowledge Generation	None	--	--
Gender Equality and Human Rights	None	--	--
Others (if any)	None	--	--

Table of Annexes

Annex 1: Terms of reference

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.[1]

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.

****Please note the following colour code:**
Text in blue = instruction to guide organization on how to prepare that specific section.
Text highlighted in yellow = sections that need specific inputs by grantee organization

1. Background and Context

1.1 Description of the project that is being evaluated.

a) **Name of the project and the organization:** Deepening and Expanding the Cross-Sector Network Response to Sexual Violence in the DRC and Kenya: A Project to Increase Justice for Women and Girls Survivors of Sexual Violence; Physicians for Human Rights (PHR).
b) **Project duration, project start date and end date:** 3 years; January 1, 2016 – December 31, 2018.
c) **Current project implementation status with the timeframe to complete the project**: We are wrapping up final activities between now and the end of December and preparing for the evaluation.
d) **Description of the specific forms of violence addressed by the project:** Violence in the family (intimate partner violence, sexual violence, non-partner violence), violence in the community (sexual violence by non-partners (rape/sexual assault)), violence perpetrated or condoned by the state (gender-based violence during armed conflict)
e) **Main objectives of the Project:** PHR has demonstrated the value of training professionals across medical, legal, and police sectors to collect, analyze, and preserve evidence; this project will promote best practices and deepen impact by broadening the existing program; getting forensics into the curriculums of educational institutions; and expanding to new locations where the need is great and our expertise is sought.
f) **Description of targeted primary and secondary beneficiaries:** Primary beneficiaries include women/girl survivors of violence (15,000); secondary beneficiaries include government officials (50), health professionals (400), legal officers (50), and uniformed personnel (50).

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.

- Our theory of change posits that: IF there is effective training of local medical, legal, and law enforcement professionals, AND they can master forensic documentation, analysis, and preservation techniques, AND they can support one another to train and mentor additional colleagues, AND they promote best practices in university legal and medical schools, hospital procedures, government agencies, and police academy studies; THEN more clinicians, lawyers, judges and police investigators will understand the role of forensic evidence in the pursuit of justice; AND prosecutions for crimes of sexual violence will be more effective because they are evidence based; AND forensic training will be embedded in government ministries with investigative, justice, and health mandates, university medical and law schools, and police academy; WHICH WILL IN TURN Deepen and expand cross-sector response to sexual violence in ways that sustainably improve medical and psychological interventions, law enforcement

investigations, and the likelihood of justice and reparations for women and girl survivors of sexual violence. BECAUSE Forensic evidence properly collected, analyzed, and preserved creates a record of events that is difficult to dispute in justice settings; AND such documentation, rooted in science and medicine and resistant to revisionism, will support increased local and international prosecutions of sexual violence crimes and the aspiration that accountability can supplant impunity – contributing broadly to more stable, secure, and just societies.

- Strategy: The project proposed by Physicians for Human Rights will employ proven training strategies to deepen the skills of people who are already part of the regions' 13 training networks – including preparing select members to become mentors and trainers; expanding the cross-sector approach to ending impunity to new regions and countries; integrating forensic training in universities and hospitals to create "centers of excellence"; cultivating local and national governmental relationships that can promote the value of forensics and evidence-based prosecutions; conducting research to better understand the obstacles to justice for women and girl survivors of sexual violence, to support advocacy, and to confirm best practices to support expansion and replication.
- Project goal: Deepen and expand cross-sector response to SV so that: more survivors receive quality medical and psychological care; evidence collection leads to thorough investigations and stronger prosecutions; judges make evidence-based findings; the number of local and international prosecutions of SV crimes increase; and many more women and girls survivors of SV obtain justice and reparations.
- Outcomes are focused on the health, legal, and law enforcement professionals obtaining the knowledge, skills, and attitude necessary to build collaborative networks in order to create systems change that supports survivors of sexual violence in DRC and Kenya.
- Activities include training and capacity building on forensic evidence of sexual violence, MediCapt trainings and implementation, building and coordinating networks of multisectoral networks, research, and partnership building.
- Outputs include increased understanding of forensic evidence, existence of centers of excellence, and laws and other procedures changed by the government to better support survivors.

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

PHR works in the DRC in South Kivu and North Kivu and is expanding to new regions in the country, possibly Kinshasa, Ituri, and Katanga provinces that are more remote. In Kenya, trainings will continue in Nairobi and the Rift Valley region Eldoret, Naivasha, Nakuru, and Kisumu – and PHR will explore expansion to northern regions as well as the coast, if the security situation permits.

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).

UNTF: $975,000; this intervention is fully funded by UNTF.

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

Key partners include medical, legal, and law enforcement professionals, Dr. Denis Mukwege of Panzi Hospital and other key international experts on sexual violence and forensic evidence, government and health officials in Kenya and DRC, and other implementing organizations in the area. PHR also works to share our in-country experiences in a variety of international arenas, including the Assembly of State Parties at the International Criminal Court, major international conferences, the World Bank, the U.S. Department of State, and others.

[1] 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).

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, medical and legal record reviews will be conducted to capture survivor-level outcomes concerning the completeness of documentation in survivor records, adjudication outcomes concerning survivor cases, and overall thoroughness of medical forensic documentation for survivor cases. To triangulate findings concerning the linkages between sectors that have been built in support of survivors of sexual assault, semi-structured qualitative interview data with personnel in the medical, law enforcement, and legal sectors will be conducted and analyzed.

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 may also be published in a peer-reviewed journal in order to further inform other stakeholders of the results of the evaluation. The findings of this evaluation will be shared and discussed with program staff, partners, participants, and other relevant stakeholders to understand how to improve PHR's work.

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 on January 1, 2016 and that was brought to a close on December 31, 2018. Legal and medical records will be retrospectively evaluated to cover pre-project periods (three years prior to PHR intervention in a jurisdiction/locale) and exposure/post-exposure project periods.

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. However, the record reviews that will take place will focus on Kenya, as access to records is more reliable, valid, and logistically feasible. A target sampling strategy will be used to select medical and legal facilities for inclusion in the medical and legal record reviews.

Target groups to be covered
This evaluation will triangulate survivor-level impact through three major units of analysis: 1. The legal records of survivors of sexual assault; 2. The medical records of survivors of sexual assault; and 3. 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 used 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. 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 goals;

b. To generate key lessons and identify promising practices for learning;
c. Inform the greater practitioner and research communities about the impact of PHR's 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	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?

5 Evaluation Methodology

This evaluation will utilize a mixed methods approach including a medical and legal record review, semi-structured interviews with PHR program trainees, and administrative program data.

Methodological Aspect	Description
1. Proposed evaluation design	We will use a mixed methods research strategy for this evaluation. The quantitative component will include a pre-intervention, post-intervention two group (control, intervention) interrupted time series without random selection to evaluate in the medical and legal records of survivors of sexual assault who would be affected by the PHR program. Interrupted time series is perhaps the strongest quasi-experimental design to evaluate longitudinal effects of time-delimited interventions (such as the one implemented by PHR). Further, we will evaluate semi-structured interview data with trainees in the medical, law enforcement, and legal sectors (qualitative).
2. Data sources	Legal records of sexual assault, medical records of sexual assault, and semi-structured interviews with PHR program trainees, and administrative program data.
3. Proposed data collection methods and analysis	Legal and medical record archival reviews will be statistically analyzed using segmented regression analysis of interrupted time series data, which allows for a statistical assessment of the level to which the intervention changed an outcome of interest relative to time. Semi-structured interviews with providers will be analyzed using a grounded theoretical coding approach to transcripts produced from the interviews.
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.

Quantitative component

In order to evaluate whether the PHR program did indeed impact completeness of documentation, adjudication outcomes, and overall thoroughness of medical forensic documentation, we will conduct a systematic review of medical and legal archives to assess how jurisdictional exposure to the PHR training program impacted these domains. We will do this by evaluating an interrupted time series of select outcomes among case and control cases in jurisdictions relative to PHR program exposure.

Hypotheses

To evaluate the impact of the PHR program on medical and court records for survivors of sexual assault in Kenya and the DRC, our hypotheses are:

> H1: Sexual assault cases occurring in jurisdictions with multi-sector actors who have been exposed to the PHR program will exhibit more complete medical and legal documentation in their case files in the years following exposure to the PHR program.

H2: Sexual assault cases occurring in jurisdictions with multi-sector actors who have been exposed to the PHR program will exhibit more adjudication outcomes favoring the survivor of sexual assault.

H3: Sexual assault cases occurring in jurisdictions with multi-sector actors who have been exposed to the PHR program will exhibit improvements in the thoroughness of medical forensic documentation of sexual assault.

Methods

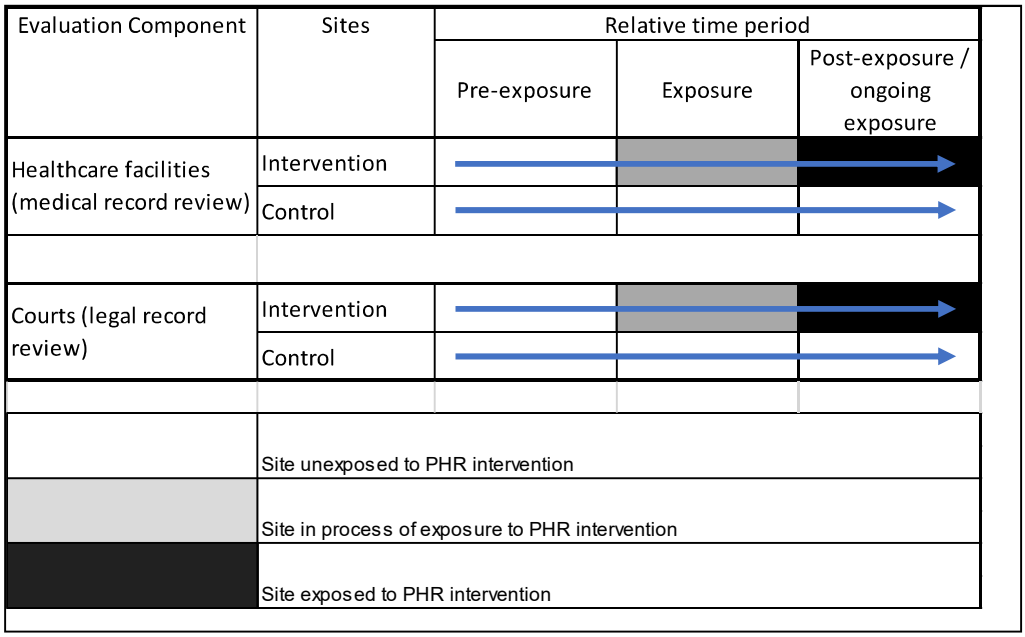
We will evaluate the above three hypotheses using an interrupted time series design in two intervention sites (jurisdictions) and two control sites in Kenya (four separate sites total). We will treat the medical record review and legal record reviews separately, as two separate experiments under the larger impact analysis framework.

We chose to conduct medical and legal record reviews given that the reviews would incur minimal risks and no burden to survivors of sexual assault. Medical and court records are entered into archives on a continuing basis as part of normal business operations (pre, during, and following PHR program exposure in a jurisdiction) and we will thus aggregate data at temporal periods within sites (by month) to best determine how exposure to the PHR program may have affected case documentation and case outcomes relative to time in intervention and control sites.

Design

We will use a pre-intervention, post-intervention two group (control, intervention) interrupted time series without random selection to evaluate the outcomes described above. Interrupted time series is perhaps the strongest quasi-experimental design to evaluate longitudinal effects of time-delimited interventions (such as the one implemented by PHR), and segmented regression analysis of interrupted time series data allows for a statistical assessment of the level to which an intervention changed an outcome of interest relative to time (See Figure below).[1]

Figure 1. Pre-intervention, post-intervention two group (control, intervention) interrupted time series without random selection to evaluate impact of PHR program.*



[1] Wagner A, Soumerai S, Zhang F, Ross-Degnan D. Segmented regression analysis of interrupted time series studies in medication use research. Journal of Clinical Pharmacy and Therapeutics (2002) 27, 299–309

**Arrows represent monthly data that will be analyzed using segmented regression analysis of the interrupted time series. Interruptions occur at the commencement of the intervention exposure periods.*

Sample

It is generally recommended that for interrupted time series analysis, there are at minimum 12 observation points during and 12 observation points following the intervention, allowing for an adequate assessment of both level and trends associated with the exposure period.[2] Given that the multi-sector response to sexual violence involves an appreciable lag for evidence to make it into a court record (sometimes taking months if not years), we will plan to expand these parameters to include a three-year (36-month) pre-observation period for all intervention and control sites, followed by an analysis of records leading into the present, depending upon when an intervention took place in a jurisdiction (this might allow for a full three year post-exposure period).

For both court record and medical record reviews at intervention and control sites, all case files of sexual assault will be selected and temporally sorted according to the date at which the survivor was examined at the medical facility (for medical record reviews), or the date proceedings began (for legal record reviews). Based upon the available number of records, a sampling interval will be calculated to select the number of cases that will be sampled for a given year. Assuming pre and post PHR program exposures reflected in medical records, and an unknown documentation of medical record quality (0.5), 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. Thus, 189 medical records pre and 189 medical records post exposure (or n=400 at each site) will be the goal of collection (approximately 66 per year, or 5 per month).[3] If less records are available, the apparent population of records will be sampled.

Data collection

A trained team of data collectors will conduct the medical and legal record reviews at intervention and control sites. Data collectors will not collect or record any personal identifiers. A description of medical and legal data collection procedures is provided below.

Medical record review

The medical record review form contains items and questions that will measure medical documentation completeness (Hypothesis 1) and medical documentation thoroughness (Hypothesis 3). Trained data collectors will be tasked to populate medical review forms for sampled records at intervention and control sites. The medical record review form contains 63 questions/items. Individual patient identifiers will not be recorded in the medical review collection form, and responses will be recorded in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, where the investigator/data collection team does not contact the subjects, and the investigator/data collection team will not re-identify subjects. In order to avoid paperwork burden and to increase security, data will be electronically collected on tablet devices and uploaded to a centralized server that uses SSL encryption. No individual codes or identifiers will be accessible or retrievable in the datasets.

[2] Wagner A, Soumerai S, Zhang F, Ross-Degnan D. Segmented regression analysis of interrupted time series studies in medication use research. Journal of Clinical Pharmacy and Therapeutics (2002) 27, 299–309

[3] Newcombe, R. G. 1998. 'Interval Estimation for the Difference Between Independent Proportions: Comparison of Eleven Methods.' Statistics in Medicine, 17, pp. 873-890.

Legal record review

The legal record review form contains items and questions that will measure legal documentation completeness (Hypothesis 1) and adjudication outcomes (Hypothesis 2). Trained data collectors will be tasked to populate the legal review forms for sampled records at intervention and control sites. The medical record review form contains 87 questions/items. Individual identifiers will not be recorded in the legal review collection form, and responses will be recorded in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, where the investigator/data collection team does not contact the subjects, and the investigator/data collection team will not re-identify subjects. In order to avoid paperwork burden and to increase security, data will be electronically collected on tablet devices and uploaded to a centralized server that uses SSL encryption. No individual codes or identifiers will be accessible or retrievable in the datasets.

Data analysis

Quantitative analyses will take place using Microsoft Excel and STATA statistical software. Data will be collapsed by month. We will examine the first 10 autocorrelations for each outcome series, and calculate the Durbin-Watson statistic based on standard least squares regression to examine autocorrelation in the residuals. We plan to use segmented regression models described by Wagner et al (2002)[4] to evaluate PHR program exposure effects on select outcomes. The authors describe that segmented regression analysis fits a least squares regression line to each segment of the independent variables, and allows for specification of the following linear regression model to estimate the trend and level in outcomes relative to PHR program exposure, where:

$$Y_t = \beta_0 + \beta_1(time_t) + \beta_2(exposure_t) + \beta_3(time\ after\ exposure_t) + e_t.$$

In the above equation, Y_t is the outcome being evaluated for a given hypothesis in month t, time is a continuous variable representing time in months at time t from the start of the observation period; exposure is an indicator for time t occurring before (exposure =0) or after (intervention=1) PHR program entry into a jurisdiction, and *time after intervention* is a continuous variable counting the number of months after the intervention at time t. β_0 estimates the baseline level of the outcome; β_1 estimates the change in the outcome that occurs with each month before PHR program exposure, β_2 estimates the level change in the outcome after exposure to the PHR program, and β_3 estimates the change in the outcome after PHR program exposure compared with the monthly trend prior to PHR program exposure. The sum of β_1 and β_3 is the post-intervention slope.[5]

[4] Wagner A, Soumerai S, Zhang F, Ross-Degnan D. Segmented regression analysis of interrupted time series studies in medication use research. Journal of Clinical Pharmacy and Therapeutics (2002) 27, 299–309

[5] Wagner A, Soumerai S, Zhang F, Ross-Degnan D. Segmented regression analysis of interrupted time series studies in medication use research. Journal of Clinical Pharmacy and Therapeutics (2002) 27, 299–309

QUALITATIVE COMPONENT

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.

Throughout the course of the UNTF grant, qualitative semi-structured interviews have been collected with PHR trainees to evaluate known UNEG domains that appear in this impact analysis. A purposive sample of trainees was selected for participation in qualitative interviews. The interviews were be structured to address the effectiveness, relevance, efficiency, sustainability, perceived impact, and knowledge gained from the PHR program. The interviews were approved by the Georgetown University IRB and were audio-recorded and transcribed. Interview subjects were selected from PHR training participant lists. Interviews occurred in private locations out of earshot range of other individuals. All interviews were audio-recorded. For this analysis, interviews will be 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, 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 Georgetown University IRB. Below are a list of special considerations regarding both of the research methods that will be used to conduct the impact evaluation.

Additional ethics considerations regarding legal and medical archival reviews

We will examine records abstracted from healthcare and legal facilities in Kenya to determine time series patterns in sexual violence case characteristics occurring from pre-exposure to current/ongoing exposure periods. This study is a retrospective study of medical and legal record quality and case outcomes associated with sexual violence cases presenting in a jurisdiction or healthcare facility. We will examine frequencies and temporal patterns of the outcome measures in de-identified case records that have been extracted onto an electronic 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 case characteristics relative to the implementation of the PHR program.

The purpose of this project is program evaluation. All the 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 consider the results of the evaluation. The record reviews we propose would qualify as exempt research under US federal human subjects regulations 45 CFR 46.104 (d)(4)(ii).[6] The record reviews we propose in this protocol are secondary research endeavors for which consent is not required, and where information, which may include information about biospecimens, is recorded by the investigator/data collection team in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, where the investigator/data collection team does not contact the subjects, and the investigator/data collection team will not re-identify subjects. De-identified data will be collected electronically and uploaded to a centralized server that uses SSL encryption. No individual codes or identifiers will be accessible or retrievable in the datasets.

Additional ethics considerations regarding semi-structured interviews

The semi-structured interviews collected by the program during the program's duration received IRB approval from the Georgetown University IRB. Semi-structured interview participants were asked to verbally consent to the interview. The interviewer initialed the consent statements. The verbal consent forms included 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.

PHR's evaluators recruited program training participants (healthcare, law enforcement, and legal professionals) to participate in semi-structured interviews as part of the project outcomes evaluation.

Individuals were recruited from the population of individuals trained by the PHR Program on Sexual Violence in Conflict Zones. Training program participants were asked to participate in a one hour interview with a member of the research team. If subjects could not communicate comfortably in English, simultaneous translation was used to interview participants. The translator was an individual who was independent from the PHR program and from the profession of the trainees involved, and who was experienced in conducting interviews where sensitivity of the information discussed may be of concern. All interviews were conducted in private, closed offices, spaces, or locations out of earshot range in which their privacy will be assured. A semi-structured interview guide was used 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 were audio-recorded and stored on a SD chip that will be with the researcher during all times in the field. The SD chip was used to extract audio recordings, which were transcribed. Transcription files were 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 semi-

[6] Electronic Code of US Federal Regulations, PART 46—PROTECTION OF HUMAN SUBJECTS. e-CFR data in effect on July 19, 2018. URL: https://www.govinfo.gov/, accessed September 6, 2018.

structured interview activity will be redacted accordingly to protect subjects' identity if a quote is used.

7 Key deliverables of evaluators and timeframe

Deliverable	Description of Expected Deliverables	Timeline of each Deliverable (date/month/year)
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.	18/10/2018
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.	15/02/2019
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.	26/02/2019

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 1 national consultant(s).

Evaluator A (e.g. senior evaluator) 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.

Two consultants will assist with data collection.

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.

National Staff

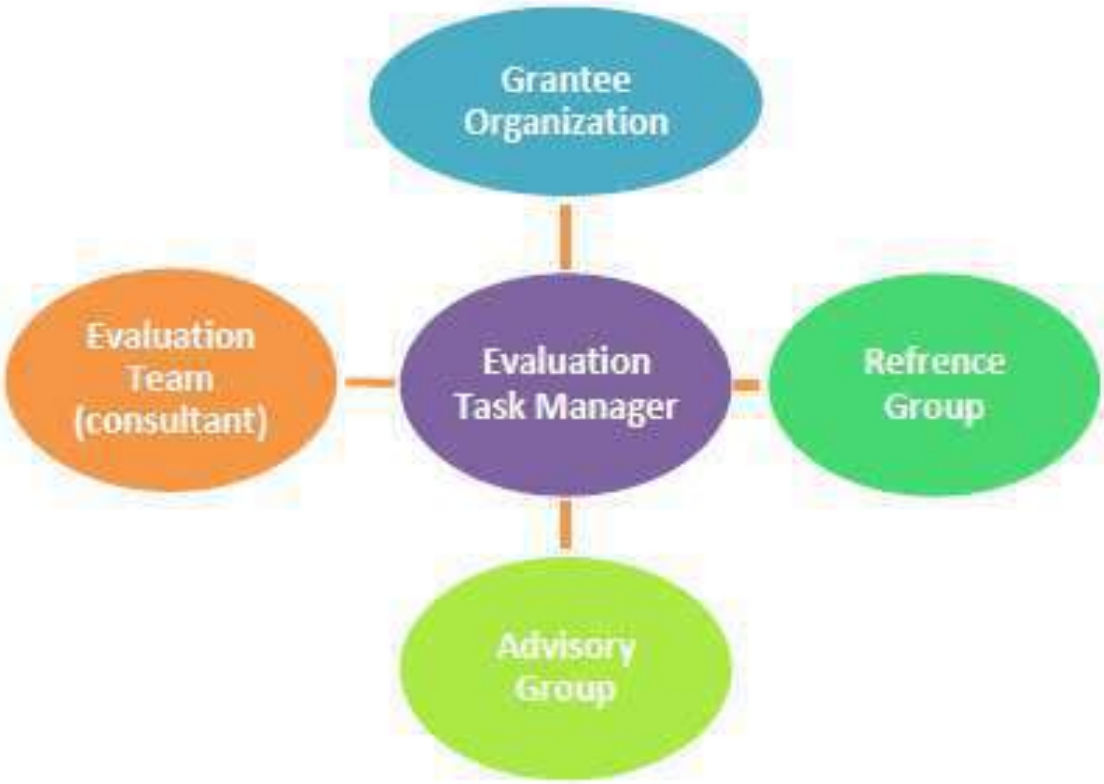
Consultants (2)

- Research coordination and collection experience of at least 5 years in working with international evaluations and/ or research studies
- Familiarity 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/or 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	Roles 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.	Katy Johnson, Program Officer, Physicians for Human Rights
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, Program Director, Physicians for Human Rights
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.	UN Trust Fund Portfolio Manager – Anna Alaszewski



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	6	12/09/2018-17/09/2018
	Compiling key documents and existing data		1	18/09/2018
	Recruitment of external evaluator(s)		1	26/09/2018
Inception stage	Briefings of evaluators to orient the evaluators	Evaluation Task Manager	1	01/10/2018
	Desk review of key documents	Evaluation Team	1	02/10/2018 – 03/10/2018
	Finalizing the evaluation design and methods	Evaluation Team	1	03/10/2018
	Preparing an **inception report**	Evaluation Team	1	04/10/2018 – 08/10/2018
	Review Inception Report and provide feedback	Evaluation Task Manager, Reference Group and Advisory Group	1	08/10/2018 – 10/10/2018
	Submitting final version of **inception report**	Evaluation Team	1	15/10/2018
Data collection and analysis stage	Desk research	Evaluation Team	15	1/10/2018-15/02/2019
	In-country technical mission for data collection (visits to the field, interviews, questionnaires, etc.)	Evaluation Team	30	01/01/2019-01/02/2019
Synthesis and reporting stage	Analysis and interpretation of findings	Evaluation Team	16	25/01/2019-11/02/2019
	Preparing a **draft report**	Evaluation Team	20	25/01/2019-15/02/2019

	Review of the draft report with key stakeholders for quality assurance	Evaluation Task Manager, Reference Group, Commissioning Organization Senior Management, and Advisory Group	5	15/02/2019-20/02/2019
	Consolidate comments from all the groups and submit the consolidated comments to evaluation team	Evaluation Task Manger	1	20/02/2019
	Incorporating comments and revising the evaluation report	Evaluation Team	7	20/02/2019-25/02/2019
	Submission of the **final report**	Evaluation Team	1	25/02/2019
	Final review and approval of report	Evaluation Task Manager, Reference Group, Commissioning Organization Senior Management, and Advisory Group	2	26/02/2019
Dissemination and follow-up	Publishing and distributing the final report	Commissioning Organization led by Evaluation Task Manager	3	27/02/2019 – 10/03/2019
	Prepare management responses to the key recommendations of the report	Senior Management of Commissioning Organization	2	10/03/2019 – 15/03/2019
	Organize learning events (to discuss key findings and recommendations, use the finding for planning of following year, etc)	Commissioning Organization	5	10/03/2019 – 25/03/2019

11 Budget

[This section should indicate total dollar amount and other resources available for the evaluation (consultant fees, travel, subsistence allowance, etc.). This is not a detailed budget but should provide information sufficient for evaluators to propose an evaluation design that is feasible within the limits of available time and resources.]

The total budget for this evaluation is USD 10,000.

12 Annexes

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

2) **Documents to be consulted**

Relevant national strategy documents

Kenya Ministry of Public Health National Guidelines on Management of Sexual Violence 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 Canada. 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.

Mishori R, Anastario M, Naimer K, Varanasi S, Ferdowsian H, Abel D, Chugh K (2017). mJustice: Preliminary Development of a Mobile App for Medical-Forensic Documentation of Sexual Violence in Low-Resource Environments and Conflict Zones. Glob Health Sci Pract. Mar 28;5(1):138-151. doi: 10.9745/GHSP-D-16-00233. Print 2017 Mar 24.

Ferdowsian H, Kelly S, Burner M, Anastario M, Gohlke G, Mishori R, McHale T & Naimer K. (2016). Attitudes Toward Sexual Violence Survivors: Differences Across Sectors in Kenya and the Democratic Republic of the Congo. J Interpers Violence. Mar 27. doi: 10.1177/0886260516639257.

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.

3) **Required structure for the inception report**

1) Background and Context of Project
2) Description of Project
3) Purpose of Evaluation
4) Evaluation Objectives and Scope
5) Final version of Evaluation Questions with evaluation criteria
6) Description of evaluation team, including the brief description of role and responsibilities of each team member
7) Evaluation Design and Methodology a. Description of overall evaluation design
    a. Data sources (accesses to information and to documents)
    b. Description of data collection methods and analysis
    c. Description of sampling
    d. Limitations of the evaluation methodology proposed

8) Ethical considerations:
    a) Safety and security (of participants and evaluation team); and
    b) Contention strategy and follow up
9) Work plan with the specific timeline and deliverables by evaluation team (up to the submission of finalized report)
10) Annexes
    a. Evaluation Matrix [see Annex 4A for the template]
    b. Data collection Instruments
    c. List of documents consulted so far and those that will be consulted
    d. List of stakeholders/partners to be consulted (interview, focus group, etc.)
    e. Draft outline of final report (in accordance with the requirements of UN Trust Fund [see Section 4.4 of this guideline document])

4) **Required structure for the 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 Contents**

3. **List of acronyms and abbreviations**

4. **Executive summary**
    [A standalone synopsis of the substantive elements of the evaluation report that provides a reader with a clear understanding of what was found and recommended and what has been learnt from the evaluation. It includes]:
    - 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**
    [The project being evaluated needs to be clearly described. Project information includes]:
    - 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 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 Reference indicators and benchmarks/baseline, where relevant (previous indicators, national statistics, human rights 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

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.

1) **Final Version of Terms of Reference (TOR) of the evaluation**
2) **Evaluation Matrix** [see Annex 4A for the template] please provide indicators, data source and data collection methods per evaluation question.
3) **Final version of Results Monitoring Plan** [see Annex 4B for the template] please provide actual baseline data and endline data per indicator of project goal, outcome and output
4) **Beneficiary Data Sheet** [see Annex 4C for the template] please provide the total number of beneficiaries reached at the project goal and outcome levels.
5) **Additional methodology-related documentation**, such as data collection instruments including questionnaires, interview guide(s), observation protocols, etc.

6) **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.]

7) **List of supporting documents reviewed**

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

Template for Evaluation Matrix

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods

Template for 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			
Women prisoners			
Others (specify)			
Primary Beneficiary Total			
Civil society organizations (including NGOs)	Number of institutions reached	NA	
	Number of individuals reached	NA	

Community-based groups/members	Number of groups reached	NA	
	Number of individuals reached	NA	
Educational professionals (i.e. teachers, educators)		NA	
Faith-based organizations	Number of institutions reached	NA	
	Number of individuals reached	NA	
General public/community at large		NA	
Government officials (i.e. decision makers, policy implementers)		NA	
Health professionals		NA	
Journalists/Media		NA	
Legal officers (i.e. lawyers, prosecutors, judges)		NA	
Men and/or boys		NA	
Parliamentarians		NA	
Private sector employers		NA	
Social/welfare workers		NA	
Uniformed personnel (i.e. police, military, peace-keeping officers)		NA	
Others (specify)		NA	
Secondary Beneficiary Total		NA	

Annex 2: Evaluation matrix

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
Effectiveness	To what extent were the intended project goal, outcomes and outputs (project results) achieved and how?	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) Percent of legal records with key domains documented; 5) Percent of legal records with key medical evidence collected; 6) Experiences of healthcare, law enforcement, and legal sector trainees in conducting investigations and in providing services to survivors of sexual assault	**Data sources**: Medical records, legal records, semistructured interviews, pre and post training questionnaires **Data collection methods**: • *Medical record review* • *Legal record review* • *Semistructured interviews with PHR trainees and stakeholders* • *Pre and post training questionnaires with PHR trainees relative to PHR trainings*
Relevance	To what extent do the achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?	1) Percent of female survivor medical records with key domains documented; 2) Percent of female survivor medical records with key medical evidence collected; 3) Percent of female survivor legal records with key domains documented;	**Data sources**: Medical records, legal records, semistructured interviews **Data collection methods**: • *Medical record review subset to female cases only* • *Legal record review subset to female cases only*

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
		4) Percent of female survivor legal records with key medical evidence collected; 5) Experiences of healthcare, law enforcement, and legal sector trainees regarding specific cases where PHR initiatives affected the lives of women and girls	• *Semistructured interviews with PHR trainees and stakeholders focused on female cases*
Efficiency	To what extent was the project efficiently and cost-effectively implemented?	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) 4) Cross-sectoral experiences of healthcare, law enforcement, and legal sector trainees in processing sexual violence cases	**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	To what extent will the achieved results, especially any positive changes in the lives of women and girls (project goal level), be sustained after this project ends?	1) Forecasted percent of medical and legal records with select domains documented; 2) Forecasted percent of medical and legal records with select medical evidence collected; *3)* Experiences of healthcare, law enforcement, and legal sector trainees in training new colleagues	**Data sources**: Medical records, semistructured interviews **Data collection methods**: • *Medical record review with ARIMA analysis and forecasting* • *Legal record review with ARIMA analysis and forecasting* • *Semistructured interviews with PHR trainees and stakeholders*

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
Impact	To what extent has the project contributed to ending violence against women, gender equality and/or women's empowerment (both intended and unintended impact)?	1) Completeness of medical and legal documentation in survivor case files 2) Adjudication outcomes favoring the survivor of sexual assault 3) Thoroughness of medical forensic documentation of sexual assault 4) Experiences of healthcare, law enforcement, and legal sector trainees with survivor cases and case outcomes *5)* Experiences of healthcare, law enforcement, and legal sector trainees with unintended consequences	**Data sources**: Medical records, legal records, semistructured interviews **Data collection methods**: • *Medical record review with interrupted time series analysis* • *Legal record review with interrupted time series analysis* • *Semistructured interviews*
Knowledge generation	To what extent has the project generated knowledge, promising or emerging practices in the field of EVAW/G that should be documented and shared with other practitioners?	1) Experiences of healthcare, law enforcement, and legal sector trainees with regarding to knowledge sharing 2) Number of new research projects conducted across eastern DRC, the Rift Valley region of Kenya, and the new program country, annually.	**Data sources**: Semistructured interviews, program records **Data collection:** • *Semistructured interviews* • *Program record monitoring spreadsheet*
Gender Equality and Human Rights	Cross-cutting criteria: the evaluation should consider the extent to which human rights based and gender responsive	1) Number of protocols or laws changed in eastern DRC and the Rift Valley region of Kenya as a result of advocacy efforts by project end. 2) Status of reforms recommended by PHR (leadership bought in;	**Data sources**: Program records, semistructured interviews **Data collection:** • *Program record monitoring spreadsheet* • *Semistructured interviews*

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
	approaches have been incorporated through-out the project and to what extent.	negotiated; implementation in process; fully implemented) in eastern DRC, the Rift Valley region of Kenya by project end. 3) PHR trainee perceptions of Physicians for Human Rights	

Annex 3: Beneficiary data sheet

TOTAL BENEFICARIES REACHED BY THE PROJECT

Type of Primary Beneficiary	Number
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/ girls with disabilities	
Women/ girls living with HIV/AIDS	
Women/ girls survivors of violence	
Women prisoners	
Women and girls in general	18,261
Other (Specify here:)	
TOTAL PRIMARY BENEFICIARIES REACHED	-
Type of Secondary Beneficiary	**Number**
Members of Civil Society Organizations	
Members of Community Based Organizations	
Members of Faith Based Organizations	
Education Professionals (i.e. teachers, educators)	
Government Officials (i.e. decision makers, policy implementers)	
Health Professionals (doctors, nurses, medical practioners)	621
Journalists / Media	
Legal Officers (i.e. Lawyers, prosecutors, judges)	95
Men and/ or boys	
Parliamentarians	
Private sector employers	
Social/ welfare workers	
Uniformed personnel (i.e. Police, military, peace keeping)	126
Other (Specify here:)	196
TOTAL SECONDARY BENEFICIARIES	1,038
Indirect beneficaries reached	**Number**
Other (total only)	
GRAND TOTAL	19,299

Annex 4: Methodology-related documentation

Legal record review form

Medical record review form

Informed consent script

Semi-structured interview guide for individuals who have been trained by PHR and for mentors of new colleagues

Pre/post training questionnaire

Program monitoring sheet

IRB Approvals

Legal record review form

Question	Item	Response set coding
1A	Name of the court where files are being accessed	[text response]
1B	Date proceedings began	##/##/####
2	Did the survivor testify in court?	0=No, 1=Yes, 999=Missing
	Survivor characteristics:	
3	Age of survivor	##
4	Sex of survivor	0= Male; 1=Female, 99=missing
5	Marital status	1=Married; 2=Partnered but not married; 3=Widowed; 4=Polygamous marriage; 5=Other; 99=Missing
6	Disability	1=not disabled, 2=disabled
7	Occupation	[text response]
8	Highest education level complete	1= eight years of basic education not complete, 2=completed eight years of basic education, 3= four years of secondary education not complete, 4= four years of secondary education completed, 5= four-year undergraduate curriculum not complete 6=completed four years of undergraduate curriculum.
9	Citizenship	1=Kenyan, 2=Other
10	Date assault was reported	[dd/mm/yyyy]
	Assault characteristics:	
11	Victim-assailant relationship	1=perpetrator unknown, 2=family, 3=friends, 4=acquaintances, 5=other
12	Number of assailants	##
	Perpetrator characteristics (fill out for each perpetrator)	
13	Age of perpetrator	##
14	Sex of perpetrator	0=Male, 1=Female, 99=missing
15	Martial status	1=Married; 2=Partnered but not married; 3=Widowed; 4=Polygamous marriage; 5=Other; 99=Missing
16	Disability	1=not disabled, 2=disabled
17	Occupation	[text response]
18	Highest education level complete	1= eight years of basic education not complete, 2=completed eight years of basic education, 3= four years of secondary education not complete, 4= four years of secondary education completed, 5= four-year undergraduate curriculum not complete

		6=completed four years of undergraduate curriculum.
19	Citizenship	1=Kenyan, 2=Other
20	Type of assault	1=oral, 2=anal, 3=vaginal, 4=other
21	Was a condom used	0=No, 1=Yes, 999=Missing
22	Were weapons used	0=No, 1=Yes, 999=Missing
23	Was the assault witnessed?	0=No, 1=Yes, 999=Missing
24	Did the survivor have a history of a previous sexual assault?	0=No, 1=Yes, 999=Missing
	Charge sheets	
25	Presence of a charge sheet in the file	0=No, 1=Yes, 999=Missing
26	The name of the offence committed	[text response]
27	Date of conviction	[dd/mm/yyyy]
28	Is a photograph of the convict present?	0=No, 1=Yes, 999=Missing
	MEDICAL	
29	Did a doctor or clinical officer testify court	0=No, 1=Yes, 999=Missing
30	P3 form present	0=No, 1=Yes, 999=Missing
31	PRC form present	0=No, 1=Yes, 999=Missing
32	Is the PRC form present	0=No, [skips to question 49], 1=Yes [goes to question 33]
33	Was the date and time of examination documented?	0=No, 1=Yes
34	Date of examination	Enter date of examination
35	Was the date and time of the incident documented?	0=No, 1=Yes
36	Date of incident	Enter date of assault
37	Number of perpetrators	Enter number, 999=missing
38	Alleged perpetrators were:	1=Male, 2=Female, 3=Unknown, 4=Known Enter age, 999=missing
39	Estimated age of perpetrator	Enter age, 999=missing
40	Is the location of the incident recorded?	0=No, 1=Yes
41	Is the chief complained “observed” section filled out?	0=No, 1=Yes
42	Is the chief complaint “reported” section filled out?	0=No, 1=Yes
43	Is the section “circumstances surrounding the incident” filled out?	0=No, 1=Yes
44	Type of sexual violence	1=Oral, 2=Vaginal, 3=Anal, 4=Other
45	Was a condom used?	1=Yes, 2=No, 3=Unknown
46	Was the incident already reported to the police?	0=No, 1=Yes
47	Did the survivor attend a health facility before this one?	0=No, 1=Yes, 999=Missing
48	Were body maps completed?	0=No, 1=Yes
	Part B of Medical Record	
49	Is Part B of the Medical Record complete?	0=No, 1=Yes, 999=Missing
50	Was it completed at the same time as the PRC form?	0=No, 1=Yes, 999=Missing
51	Did the judge ask for part B to be completed at a date later than the PRC form was completed?	0=No, 1=Yes, 999=Missing
52	Is there a mental health assessment outside of Part B of the PRC form?	0=No, 1=Yes, 999=Missing

53	Injury type (if not obtained from PRC)	Mary all that apply: 1=anogenital, 2=head/neck, 3=limbs, 4=chest, 5=back, 6=abdomen, 7=skin
54	Forensic photography present	0=No, 1=Yes, 999=Missing
55	Chain of custody documentation	0=No, 1=Yes, 999=Missing
56	Report from government chemist	0=No, 1=Yes, 999=Missing
57	Other laboratory requests/results	0=No, 1=Yes, 999=Missing
	Other documents from hospital	
58	Is a letter/s from the hospital present?	0=No, 1=Yes, 999=Missing
59	Are treatment notes present?	0=No, 1=Yes, 999=Missing
60	Is a discharge summary report present?	0=No, 1=Yes, 999=Missing
61	Are X-ray reports present	0=No, 1=Yes, 999=Missing
62	Are ultrasound reports present?	0=No, 1=Yes, 999=Missing
63	Are CT scan reports present?	0=No, 1=Yes, 999=Missing
	Other documents	
64	Are pre-bond reports present?	0=No, 1=Yes, 999=Missing
65	Is there evidence of bond payment?	Select all that apply: 1=title deeds, 2=log books, 3=pay slips, 4=mortgages
66	Is there a cash bail receipt copy in court file?	0=No, 1=Yes, 999=Missing
67	Is there a social assessment report for survivor?	0=No, 1=Yes, 999=Missing
68	Is there a social assessment report for the perpetrator?	0=No, 1=Yes, 999=Missing
	Export reports	
69	Are ballistic reports present?	0=No, 1=Yes, 999=Missing
70	Is there blood spatter analysis present	0=No, 1=Yes, 999=Missing
71	Are other expert reports present?	0=No, 1=Yes, 999=Missing
72	Is a crime scene report present?	0=No, 1=Yes, 999=Missing
73	Is there a list of exhibits?	0=No, 1=Yes, 999=Missing
74	Is there a list of witnesses	0=No, 1=Yes, 999=Missing
75	Is there evidence recorded by a judicial officer?	0=No, 1=Yes, 999=Missing
76	If yes, describe	[text response]
	For child cases	
77	Birth certificate present	0=No, 1=Yes, 999=Missing
78	Child immunization card present	0=No, 1=Yes, 999=Missing
79	Birth notification (for children without birth certificate)	0=No, 1=Yes, 999=Missing
80	Parental statement regarding child's age	0=No, 1=Yes, 999=Missing
81	Age assessment report present	0=No, 1=Yes, 999=Missing
	Perpetrator	
82	Name of the advocate of the accused if the perpetrator	[text response]
83	Adjunction outcome/ruling	[text response]
84	The name of the court that convicted the perpetrator	[text response]
85	Station of conviction	[text response]
86	Location of conviction	[text response]
87	Notes on reparations	[text response]

Medical record review form

Question	Item	Response set coding
1	Patient ID number assigned by study team	Enter study ID number
2	Is a PRC form present in patient's file?	0=No, 1=Yes
3	Is the PRC form dated?	0=No, 1=Yes
4	Is the date of birth documented?	0=No, 1=Yes
5	Enter the date of the patient's birth	##/##/####
6	Gender of the patient	0= Male; 1=Female, 99=missing
7	Marital status of patient	1=Married; 2=Partnered but not married; 3=Widowed; 4=Polygamous marriage; 5=Other; 99=Missing
8	Was the date and time of examination documented?	0=No, 1=Yes
9	Date of examination Enter date of examination	
10	Was the date and time of the incident documented?	0=No, 1=Yes
11	Date of incident	Enter date of assault
12	Number of perpetrators	Enter number, 999=missing
13	Alleged perpetrators were:	1=Male, 2=Female, 3=Unknown, 4=Known
14	Estimated Age of perpetrator	Enter age, 999=missing
15	Is the location of the incident recorded?	0=No, 1=Yes
16	Is the chief complaint "observed" section filled out?	0=No, 1=Yes
17	Is the chief complaint "reported" section filled out?	0=No, 1=Yes
18	Is the section "circumstances surrounding the incident" filled out?	0=No, 1=Yes
19	Type of sexual violence	1=Oral, 2=Vaginal, 3=Anal, 4=Other
20	Was a condom used?	1=Yes, 2=No, 3=Unknown
21	Was the incident already reported to the police?	0=No, 1=Yes
22	Did the survivor attend a health facility before this one?	0=No, 1=Yes, 999=Missing
23	Were body maps completed?	0=No, 1=Yes
24	Known pregnancy?	0=No, 1=Yes, 999=Missing
25	Date of last consensual intercourse	Enter date, 9=missing
26	Was blood pressure documented?	0=No, 1=Yes
27	Was Pulse Rate documented?	0=No, 1=Yes
28	Was RR documented?	0=No, 1=Yes
29	Was Temperature documented?	0=No, 1=Yes
30	Demeanor/Level of anxiety	Enter what is written, 999=missing
31	Did the survivor change clothes?	0=No, 1=Yes, 999=Missing
32	State of clothes	Enter what is written, 999=missing
33	How were clothes transported?	1=Plastic Bag, 2=Non-Plastic Bag, 3=Other

34	Were the clothes handed to the police?	0=No, 1=Yes, 999=Missing
35	Did the survivor go the toilet?	1=Long call, 2=Short call, 3=Missing
36	Did the survivor have a bath or clean themselves?	0=No, 1=Yes, 999=Missing
37	Did the survivor leave any marks on the perpetrator?	0=No, 1=Yes, 999=Missing
38	In the section "Genital Examination of the Survivor", indicate which of the following sections were filled out. Mark all that apply.	1=Physical injuries, 2=Outer genitalia, 3=Vagina, 4=Hymen, 5=Anus, 6=Other significant orifices
39	Is the comments section filled out?	0=No, 1=Yes
40	PEP 1st dose	0=No, 1=Yes, 999=Missing
41	ECP given	0=No, 1=Yes, 999=Missing
42	Stitching/surgical toilet done	0=No, 1=Yes, 999=Missing
43	STI treatment given	0=No, 1=Yes, 999=Missing
44	Referrals to [mark all that apply]	1=Police station, 2=HIV test, 3=Laboratory, 4=Legal, 5=Trauma Counseling, 6=Safe Shelter, 7=OPD/CCC/HIV Clinic, 8=Other
45	Swabs [mark all that apply]	1=Outer genital swab, 2=anal swab, 3=skin swab, 4=oral swab, 5=other, 6=high vaginal swab
46	Was a DNA sample sent to a laboratory?	0=No, 1=Yes, 999=Missing
47	Urine tests [mark all that apply]	1=Pregancy test, 2=Microscopy, 3=Drugs and alcohol, 4=Other
48	Blood tests [mark all that apply]	1=Haemoglobin, 2=HIV test, 3=SGPT/GOT, 4=VDRL, 5=DNA
49	Other tests [mark all that apply]	1=Pubic Hair, 2=Nail clippings, 3=Foreign bodies, 4=Other
50	Is there specification on whether samples were packed and issued?	0=No, 1=Yes
51	Is there a name and signature for the Examining Officer?	0=No, 1=Yes
52	Is there a date for the Examining Officer's signature?	0=No, 1=Yes
53	IS there a name and signature for the Police Officer?	0=No, 1=Yes
54	Is there a date for the Police Officer's signature?	0=No, 1=Yes
55	Is Part B of the PRC form completed?	0=No, 1=Yes
56	Were referrals provided following Part B?	0=No, 1=Yes
57	Referral uptake since last visit	Enter what is written, 999=missing
58	Is there any forensic photography present in the medical record?	0=No, 1=Yes, 999=Missing
59	Is informed consent documented?	0=No, 1=Yes
60	If this is a minors case, is the assent of the minor	0=No, 1=Yes

	noted?	
61	If this is a minors case, is the consent of the parent /guardian noted?	0=No, 1=Yes
62	If this is an intellectual disability case, is the assent Of individual noted?	0=No, 1=Yes
63	If this is an intellectual disability case, is the consent Of the guardian parent/model?	0=No, 1=Yes

Informed consent script

ANONYMOUS INTERVIEW

You are invited to participate in a research study titled **"**Program evaluation activities for

Physicians for Human Rights**"**. This study is being conducted by Dr. Ranit Mishori, Professor of Family Medicine at Georgetown University Medical Center and Dr. Michael Anastario, an evaluation specialist who works with Physicians for Human Rights. They are conducting this study in order to evaluate the effects of Physicians for Human Rights' Program on Sexual Violence in Conflict Zones. The results of this study will be used to improve the program and make changes where they are needed.

Participation in this study is entirely voluntary at all times. You can choose not to participate at all or to leave the study at any time. Regardless of your decision, there will be no effect on your relationship with the researchers or any other consequences.

You are being asked to take part in this study because you are someone who has either been trained by Physicians for Human Rights, or someone who works as an implementing partner with Physicians for Human Rights in the region.

If you agree to participate, you will be asked to take part in one interview about the collection and processing of forensic evidence in sexual assault cases. The questions pertain to your professional experiences in working with survivors of sexual assault, their cases, and the multi-sectoral network of individuals who also process survivors' cases. This interview should last around 60 minutes. The interview will take place in a private location at your workplace, at a hotel, or at a neutral location. The researcher will take notes during the interview and your interview will be audio recorded.

What you say during this interview will remain anonymous and cannot be linked to you in any way. No identifying information about you will be collected at any point during the study, and your recording will be identified only with a random number. If you say something during the interview that may identify you, it will be removed during the transcription of the interview. Once your interview is over, there will be no way to withdraw your responses from the study because the interview will contain no identifying information.

Study data will be kept in a digital format on a secured drive in the United States. Access to digital data will be protected by a password on a secured network drive. Only members of the study team will have access to the data.

There are no risks associated with this study. While you will not experience any direct benefits from participation, information collected in this study may benefit others in the future by helping to improve the quality of the training program, improve network activities in the region, and to improve program implementation.

If you have any questions regarding the interview or this research project in general, please contact the principal investigator, Dr. Ranit Mishori, at mishorir@georgetown.edu (email is the preferred method of contact) or at 202-687-3011. If you have any questions about your rights as a research participant, please contact the Georgetown University IRB at (202) 687-1506or irboard@georgetown.edu.

By taking part in this interview, you are indicating your consent to participate in this study.

Ranit Mishori, MD, MHS, FAAFP

Professor of Family Medicine

Director, CAPRICORN - Georgetown's PBRN (Practice-Based Research Network)

Director, Global Health Initiatives, Department of Family Medicine

Georgetown University School of Medicine MedStar
Health - Family Medicine at Spring Valley

mishorir@georgetown.edu (email is the preferred method of contact)

202-687-3011 - DO NOT LEAVE MESSAGE

Semi-structured interview guide for individuals who have been trained by PHR and for mentors of new colleagues

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?

5. Please describe the PHR events that you attended.
   Probe→Trainings, network meetings, regional roundtables, training of trainers. Probe→How many events did you attend?

6. Apart from the training you received from Physicians for Human Rights, how many other sexual violence trainings have you attended?

6. Please tell me about those other sexual violence trainings.

   Probe→Did any of them cover aspects of forensic investigation? How so?

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*

C *FOR LAW ENFORCEMENT PROFESSIONALS*

D *FOR LEGAL PROFESSIONALS*

F *FOR MENTORS TRAINING NEW COLLEAGUES*

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 survivors of sexual violence you have screened for sexual violence since the training with Physicians for Human Rights?
   Probe → How many were women/and or girl survivors of sexual violence?

3. Do you feel that the Training with Physicians for Human Rights was relevant in responding to the needs of survivors of sexual violence?
   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 materials, including forensic backpacks and curriculum companions, were distributed. Have you found the materials in the backpack to be helpful? Do you still use the materials in the backpack?
   Probe → What materials were most useful?

   Probe → what do you wish had been included but wasn't given to you?

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. Do you use the medical certificate (DRC) / Post-Rape Care Form (Kenya) when you document cases of sexual violence?

Probe → What challenges do you have using the form?

→Are there barriers to using the form?

→How do officials react to the signed form?

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?

→ did your testimony change as a result of PHR's trainings? \

→if so, how?

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?

Probe→ How has cross-sectoral collaboration changed or impacted the work that you do?

18. Do you feel that forensic evidence of sexual assault is treated any differently in your community 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 survivors?

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 sexual violence?

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 survivors of sexual violence?

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?

→ did your testimony change as a result of PHR's trainings? if so, how?

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?

Probe→ How has cross-sectoral collaboration changed or impacted the work that you do?

16. Do you feel that forensic evidence of sexual assault is treated any differently in your community 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 survivors?

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 sexual violence?

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 survivors of sexual violence?

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?

    Probe → How has cross-sectoral collaboration changed or impacted the work that you do?

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 survivors?

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 sexual violence?

E. WRAP-UP

1. Have you trained other colleagues after attending one of PHR's training workshops? Probe→ How many and who?
   →What PHR materials were useful in these trainings?
   →What do you wish you had to help you with these trainings?

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

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

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

5. What kind of support (financial and non-financial) can PHR provide to help your work?

6. How can PHR activities grow?

7. What didn't you like about PHR's trainings/ activities?

8. How could they be improved?

9. If you had access to unlimited resources to end sexual violence in your community, what would you do to make that happen?

F. QUESTIONS FOR MENTORS TRAINING NEW COLLEAGUES

1. When did you participate in a Training of Trainers session with Physicians for Human Rights?

2. How many new colleagues have you trained in cross-sectoral trainings since the Training of Trainers session?

   Probe→ where did you train these colleagues

   Probe→Have you used PHR materials to conduct these trainings? If so, what did you find helpful?

   →What would you need to help you train additional experts?

3. Do you train outside of PHR?

   Probe→Have you used PHR materials to conduct these trainings? →Did PHR's trainings help you do this?

4. Please describe your experiences training new colleagues.

   Probe→How do you structure your training sessions?

   →What components of the training curriculum do you find most helpful?

   →What components of the training curriculum do you find least helpful?

5. What would help you better train your colleagues?

6. What have been some of the challenges you have faced in training new colleagues?

7. Please describe the institutional resources that are provided to you in training and assisting new colleagues?

8. What kind of support would you need to carry out additional trainings without PHR?

Thank you for your time.

Participant ID:

Physicians for Human Rights

PROGRAM ON SEXUAL VIOLENCE IN CONFLICT ZONES

PRE-TRAINING ASSESSMENT

The following questionnaire contains items that help us better evaluate the training. This test is anonymous and your answers will not be shared with anyone. Participation in this survey is voluntary. You are free to skip questions that you are not comfortable answering.

1. What is your mobile phone number? _____

2. What is your gender? ☐ Female ☐ Male

3. What is your current age?

- ☐ 18 to 29 years
- ☐ 30 to 39 years
- ☐ 40 to 49 years
- ☐ 50 years or older

4. What is your profession?

Medical/Mental Health Sector:

- ☐ Physician
- ☐ Nurse
- ☐ Psychologist
- ☐ Social Worker
- ☐ Other: (please indicate)

_____

Legal/Judiciary Sector:

- ☐ Attorney
- ☐ Judge
- ☐ Magistrate
- ☐ Other: (please indicate)

_____

Law Enforcement Sector:

- ☐ Police Officer
- ☐ Investigator
- ☐ Other: (please indicate)

_____

5. What is your area of specialty (or expertise)? _____

6. **How** many years have you been practicing your profession? _____ years

7. In general, what **number** of clients/patients/victims that you see are:

male _____
female _____

8. In general, what **number** of clients/patients/victims that you see are:

infants: _____
children: _____
adolescents: _____
adults: _____

9. Approximately **how many** cases of sexual violence have you actively examined/interviewed/represented in the last 12 months?
_____ cases

10. **How many** of these cases of sexual violence were disclosed by the survivor without your prompting?

_____ cases

11. **How many** of these cases became known to you because you directly asked the survivor?

_____ cases

12. In the cases of sexual violence you have seen in the last 12 months, **how many** were:

male: _____
female: _____

13. In the cases of sexual violence you have seen in the last 12 months, **how many** were:

infants: _____
children: _____
adolescents: _____
adults: _____

14. In the cases of sexual violence you have seen in the last 12 months, **number** of survivors who can identify their perpetrator(s) by:

by name _____

by uniform or clothing _____

by language (including dialect and accent) _____

by ethnicity/tribal/religious affiliation _____

15. In the cases of sexual violence you have seen in the last 12 months, estimated **number** of survivors who describe more than one perpetrator?

_____

16. In the cases of sexual violence you have seen in the last 12 months, estimated **number** of survivors who describe more than one act (i.e. a one-time event) of sexual violence?

_____

Multiple Choice

Choose only one answer.

1. All EXCEPT the following are acts of sexual violence

a. Unwanted touching
b. Forced penetration with an object
c. Consensual acts among adults
d. Forced penetration with a penis

2. Which of the following are examples of sexual violence?

a. Rape
b. Forced sterilization
c. Forced pregnancy
d. All of the above

3. What criteria are necessary for informed consent?

a. Voluntariness
b. Understanding
c. Permission
d. All of the above

4. The four Guiding Principles for responders to sexual violence are:

a. Safety, Confidentiality, Respect and Non-discrimination
b. Money, Safety, Respect and Confidentiality
c. Safety, Confidentiality, Comfort and Minimizing
d. Respect, Non-discrimination, Safety and Medicine

5. Which of the following is NOT an example of the UN guiding principles in practice?

a. Developing a safety plan with a sexual violence survivor.
b. Ensuring privacy.
c. Asking unnecessary questions.
d. Treating all survivors without bias.

6. Which of the elements below is part of the clinical/forensic exam?

a. The survivor's verbal account of the incident during the medical interview (history)
b. Assessment of the survivor's psychological state
c. Written and pictorial documentation of genital and non-genital injuries
d. Torn or soiled clothing
e. Collection of evidence (such as semen)
f. All of the above

7. If the survivor discloses penile-vaginal penetration as part of the assault, the examiner should do all of the following except:

a. Not make the survivor uncomfortable with any additional questions because she/he has suffered enough
b. Ask about oral penetration
c. Ask about anal penetration
d. Ask about penetration with foreign objects

8. The following types of non-genital injuries are common in cases of sexual assault:

a. Neck bruising from choking
b. Punch or bite injuries to the breasts and nipples
c. Punch or kick injuries to the abdomen
d. Punch and kick injuries to the thighs
e. Facial bruising, abrasions, and lacerations
f. Scratches, lacerations and abrasions on the back, upper arms, and thighs
g. All of the above

9. Which of the following is true?

a. The Istanbul Protocol language can be used to describe whether physical signs (wounds and scars) are consistent with an individual's history of trauma.
b. The Istanbul Protocol language can help you make definitive conclusions about a sexual assault case
c. The Istanbul Protocol can only be used by specially trained doctors.
d. The Istanbul Protocol is a document established last year at the Hague.
e. The Istanbul Protocol is typically used by police officers.

10. If a health professional describes physical evidence as highly consistent with the history provided, it means:

a. There are only a few explanations for the physical evidence, and the history provided is one of the acceptable potential explanations.
b. The physical evidence is diagnostic of the history described.
c. The physical evidence does not correspond with the history provided.
d. The physical evidence could only be explained by the history provided.

11. A crime scene can be:

a. A place where a crime has been committed
b. The body of the victim
c. The body of the perpetrator
d. All of the above

12. Evidence can be:

a. Tangible
b. Transitory
c. Residiual
d. All of the above

13. Physical evidence that is not easily detected during a visual examination can be called:

a. Latent
b. Hidden
c. Marvellous
d. Teaser

True or False

Choose only one answer.

1. If a woman does not resist a sexual assault, then the sexual assault is her fault.

_____True _____False

2. Only women and girls can be sexually assaulted.

_____True _____False

3. It is unprofessional for someone working with survivors of sexual violence to be psychologically and/or emotionally affected by the stories they hear.

_____True _____False

4. After appropriately examining a survivor, a medical (forensic) examiner should be to diagnose sexual assault or conclusively determine whether or not assault or rape happened.

_____True _____False

5. The only way to document a sexual assault or sexual violence is to find physical evidence or changes to the genitals.

_____True _____False

6. In an examination of a vaginal rape case, it is enough for the clinician to only examine the genitalia.

_____True _____False

7. In a sexual assault case, the survivor's body is the most important source of physical evidence.

_____True _____False

8. A clinician can expect to always find physical signs in a sexual assault case with reported forced penile penetration into the vagina.

_____True _____False

9. If, during the exam and history taking, the survivor is not showing any emotions (is not crying, is calm, and/or has a flat affect), it can be assumed that she/he was not assaulted.

_____True _____False

10. A forensic sexual examination should only be conducted if the sexual assault occurred within the last 72 hours.

_____True _____False

11. Before the forensic examination is conducted, it is important to explain to the survivor what is going to happen during the visit, including all parts of the examination, and make sure that he/she understands and agrees

_____True _____False

12. The absence of seminal fluid (semen) is proof that sexual assault did not take place.

_____True _____False

13. In case of sexual violence, the police investigator must to travel to the location where the crime has been committed?

_____True _____False

14. DNA evidence is the only evidence of rape.

_____True _____False

15. DNA evidence is required to prove that rape occurred.

_____True _____False

Attitudes and Beliefs

Please indicate whether you agree or disagree with the following statements.

1. Survivors of sexual violence have gotten what they deserve.

_____Agree _____Disagree

2. If I found out that one of my family members were a victim of sexual violence, I would want it to remain a secret.

_____Agree _____Disagree

3. Survivors of sexual violence should feel ashamed for what they have done.

_____Agree _____Disagree

4. I would be willing to care for a family member if the family member was experiencing trouble as a result of sexual violence.

_____Agree _____Disagree

5. If my partner or spouse were the victim of sexual violence, I would leave him/her.

_____Agree _____Disagree

6. In my country, the destruction or loss of <u>medical records/evidence</u> concerning a sexual violence case is:

_____Very unlikely _____Somewhat unlikely _____Somewhat likely _____Very likely

Physicians for Human Rights

Participant ID:

PROGRAM ON SEXUAL VIOLENCE IN CONFLICT ZONES

POST-TRAINING ASSESSMENT

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2. What is your gender? ☐ Female ☐ Male

3. What is your current age?

- ☐ 18 to 29 years
- ☐ 30 to 39 years
- ☐ 40 to 49 years
- ☐ 50 years or older

4. What is your profession?

Medical/Mental Health Sector:

- ☐ Physician
- ☐ Nurse
- ☐ Psychologist
- ☐ Social Worker
- ☐ Other: (please indicate)

_____

Legal/Judiciary Sector:

- ☐ Attorney
- ☐ Judge
- ☐ Magistrate
- ☐ Other: (please indicate)

_____

Law Enforcement Sector:

- ☐ Police Officer
- ☐ Investigator
- ☐ Other: (please indicate)

_____

5. What is your area of specialty (or expertise)? _____

6. **How** many years have you been practicing your profession? _____ years

7. In general, what **number** of clients/patients/victims that you see are:

male _____

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8. In general, what **number** of clients/patients/victims that you see are:

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14. In the cases of sexual violence you have seen in the last 12 months, **number** of survivors who can identify their perpetrator(s) by:

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by uniform or clothing _____

by language (including dialect and accent) _____

by ethnicity/tribal/religious affiliation _____

15. In the cases of sexual violence you have seen in the last 12 months, estimated **number** of survivors who describe more than one perpetrator?

_____

16. In the cases of sexual violence you have seen in the last 12 months, estimated **number** of survivors who describe more than one act (i.e. a one-time event) of sexual violence?

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Multiple Choice

Choose only one answer.

1. All EXCEPT the following are acts of sexual violence

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4. The four Guiding Principles for responders to sexual violence are:

a. Safety, Confidentiality, Respect and Non-discrimination
b. Money, Safety, Respect and Confidentiality
c. Safety, Confidentiality, Comfort and Minimizing
d. Respect, Non-discrimination, Safety and Medicine

5. Which of the following is NOT an example of the UN guiding principles in practice?

a. Developing a safety plan with a sexual violence survivor.
b. Ensuring privacy.
c. Asking unnecessary questions.
d. Treating all survivors without bias.

6. Which of the elements below is part of the clinical/forensic exam?

a. The survivor's verbal account of the incident during the medical interview (history)
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7. If the survivor discloses penile-vaginal penetration as part of the assault, the examiner should do all of the following except:

a. Not make the survivor uncomfortable with any additional questions because she/he has suffered enough
b. Ask about oral penetration
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d. Ask about penetration with foreign objects

8. The following types of non-genital injuries are common in cases of sexual assault:

a. Neck bruising from choking
b. Punch or bite injuries to the breasts and nipples
c. Punch or kick injuries to the abdomen
d. Punch and kick injuries to the thighs
e. Facial bruising, abrasions, and lacerations
f. Scratches, lacerations and abrasions on the back, upper arms, and thighs
g. All of the above

9. Which of the following is true?

a. The Istanbul Protocol language can be used to describe whether physical signs (wounds and scars) are consistent with an individual's history of trauma.
b. The Istanbul Protocol language can help you make definitive conclusions about a sexual assault case
c. The Istanbul Protocol can only be used by specially trained doctors.
d. The Istanbul Protocol is a document established last year at the Hague.

e. The Istanbul Protocol is typically used by police officers.

10. If a health professional describes physical evidence as highly consistent with the history provided, it means:

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13. Physical evidence that is not easily detected during a visual examination can be called:

a. Latent
b. Hidden
c. Marvellous
d. Teaser

True or False

Choose only one answer.

1. If a woman does not resist a sexual assault, then the sexual assault is her fault.

_____True _____False

2. Only women and girls can be sexually assaulted.

_____True _____False

3. It is unprofessional for someone working with survivors of sexual violence to be psychologically and/or emotionally affected by the stories they hear.

_____True _____False

4. After appropriately examining a survivor, a medical (forensic) examiner should be to diagnose sexual assault or conclusively determine whether or not assault or rape happened.

_____True _____False

5. The only way to document a sexual assault or sexual violence is to find physical evidence or changes to the genitals.

_____True _____False

6. In an examination of a vaginal rape case, it is enough for the clinician to only examine the genitalia.

_____True _____False

7. In a sexual assault case, the survivor's body is the most important source of physical evidence.

_____True _____False

8. A clinician can expect to always find physical signs in a sexual assault case with reported forced penile penetration into the vagina.

_____True _____False

9. If, during the exam and history taking, the survivor is not showing any emotions (is not crying, is calm, and/or has a flat affect), it can be assumed that she/he was not assaulted.

_____True _____False

10. A forensic sexual examination should only be conducted if the sexual assault occurred within the last 72 hours.

_____True _____False

11. Before the forensic examination is conducted, it is important to explain to the survivor what is going to happen during the visit, including all parts of the examination, and make sure that he/she understands and agrees

_____True _____False

12. The absence of seminal fluid (semen) is proof that sexual assault did not take place.

_____True _____False

13. In case of sexual violence, the police investigator must to travel to the location where the crime has been committed?

_____True _____False

14. DNA evidence is the only evidence of rape.

_____True _____False

15. DNA evidence is required to prove that rape occurred.

_____True _____False

Attitudes and Beliefs

Please indicate whether you agree or disagree with the following statements.

1. Survivors of sexual violence have gotten what they deserve.

_____Agree _____Disagree

2. If I found out that one of my family members were a victim of sexual violence, I would want it to remain a secret.

_____Agree _____Disagree

3. Survivors of sexual violence should feel ashamed for what they have done.

_____Agree _____Disagree

4. I would be willing to care for a family member if the family member was experiencing trouble as a result of sexual violence.

_____Agree _____Disagree

5. If my partner or spouse were the victim of sexual violence, I would leave him/her.

_____Agree _____Disagree

6. In my country, the destruction or loss of <u>medical records/evidence</u> concerning a sexual violence case is:

_____Very unlikely _____Somewhat unlikely _____Somewhat likely _____Very likely

RRF component				year
	Indicator	Materials/methods	Country	month
Output 1.2	Number of network meetings held in eastern DRC, the Rift Valley region of Kenya, and the new program country to discuss and decide on operating structures by project end.	Use program records (e.g. sign in sheets, meeting minutes) to count the number of network meetings held monthly	**DRC**	#
			Kenya	#
Outcome 2.1	Number of new colleagues trained and mentored by PHR trainees in eastern DRC and the Rift Valley region of Kenya, annually.	Use training attendance lists for Training of Trainer activities to count the number of new colleagues trained and mentored by month	**DRC**	#
			DRC Trainees	#
			Kenya	#
			Kenya Trainees	#
Output 2.1a	Number of MoUs signed between PHR and select hospitals or universities in in eastern DRC, the Rift Valley region of Kenya, and the new program country by project end.	Use the number of signed MOUs to count the number of MoUs signed monthly	**DRC**	#
			Kenya	#
Output 2.1b	Number of patient pathway and service assessments completed at health centers in eastern DRC, the Rift Valley region of Kenya, and the new program country by project end.	Use completed patient pathway and service assessments to count the number completed monthly	**DRC**	#
			Kenya	#
Output 2.1c	Number of recommendation documents provided to health centers in eastern DRC, the Rift Valley region of Kenya, and the		**DRC**	#
			Kenya	#

RRF component	Indicator	Materials/methods	Country	year month
	new program country by project end.			
Output 2.2a	Status of plans in eastern DRC, the Rift Valley region of Kenya, and the new program country (plan being discussed within institution; plan being drafted; plan completed) that detail how institutions will integrate forensic training material into curriculums, protocols, practices, and in-service and pre-service trainings by project end.	Qualify the status of plans for each country as: A.plan being discussed within institution; B. plan being drafted; or C. Plan completed. Maintain backup documentation for qualification selected monthly. If more than one per country, show # by letter for month.	**DRC**	#
			Kenya	#
Output 2.2b	Status of agreements (under discussion; in draft stage; agreement completed and signed) between PHR and selected institutions in eastern DRC, the Rift Valley region of Kenya, and the new program country concerning details of the joint plan by project end.	Qualify the status of agreements by institution in each country as: A. under discussion; B. in draft stage; or C. agreement completed and signed. Maintain backup documentation for qualification selected monthly. If more than one per country, show # by letter for month.	**DRC**	#
			Kenya	#
Output 2.3a	The number of institutions reaching standardized benchmarks in accordance with PHR guidelines in eastern DRC, the Rift Valley region of Kenya, and the new program country by project end.	Count the number of new institutions reaching standardized benchmarks per month. Results will be tallied in a cumulative fashion, thus only provide one new entry for each institution as it reaches the standardized benchmark.	**DRC**	#
			Kenya	#

RRF component				year
	Indicator	Materials/methods	Country	month
Output 3.1	Status of reforms recommended by PHR (leadership bought in; negotiated; implementation in process; fully implemented) in eastern DRC, the Rift Valley region of Kenya, and the new program country by end of project period.	Qualify the status of reforms recommended by PHR as: A. leadership bought in; B. negotiated; C. implementation in process; D. Fully implemented. Maintain backup documentation for qualification selected monthly. If more than one per country, show # by letter for month.	**DRC**	#
			Kenya	#
Output 3.3	Number of new research projects conducted across eastern DRC, the Rift Valley region of Kenya, and the new program country, annually.	Count the number of new research projects conducted monthly. Maintain backup documentation of the technical report or published research.	**DRC**	#
			Kenya	#
Output 3.4	Number of protocols or laws changed in eastern DRC and the Rift Valley region of Kenya as a result of advocacy efforts by project end.	Count the number of protocols or laws changed by month. Keep backup documentation of new protocols or laws.	**DRC**	#
			Kenya	#

IRB Approvals

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GEORGETOWN UNIVERSITY

Georgetown University Institutional Review Board

Date: 10/3/2018

To: Ranit Mishori

From: Michael Orquiza
Institutional Review Board

IRB#: 2016-0661

Title: Program evaluation activities for Physicians for Human Rights

Approval Date: 10/3/2018

Expiration Date: 10/2/2019

Action: Continuing Review - Expedited

Your above referenced continuing review was approved through expedited review by the IRB Chair or a designee on 10/3/2018.

This is to inform you that you may continue your project.

Please note that this approval is granted until 10/2/2019. The IRB requires that you submit an application for annual renewal at the end of the approval period and/or at study completion. Please note that this office will automatically terminate the project on the date stated above, unless reviewed and re-approved by the IRB. ***It is the PI's responsibility to submit the application for annual renewal and the appropriate IRB forms at least one month before the expiration date.***

Please remember to:
1. Seek and obtain prior approval for any modifications to the approved protocol.
2. Promptly report any unexpected or otherwise significant adverse effects encountered in the course of this study to the Institutional Review Board within 7 calendar days. This includes information obtained from sources outside MedStar Health Research Institute and Georgetown University that reveals previously unknown risks from the procedures, drugs or devices used in this study.

(202)687-1506 *telephone*
(202)687-4847 *facsimile*

Georgetown University Institutional Review Board

Date:	10/9/2018
To:	Ranit Mishori
From:	Michael Orquiza Institutional Review Board
IRB #:	2018-1046
Title:	Archival record review for Physicians for Human Rights' Program on Sexual Violence in Conflict Zones
Approval Date:	10/9/2018
Expiration Date:	10/8/2019
Action:	Initial Review - Expedited

Attachments being reviewed: **3** documents were reviewed as part of this submission:

Document	Version
protocol with appendices	0.01
Legal record review form.pdf	0.01
Medical Record review form.pdf	0.01

The above-referenced study and supporting documents were approved through expedited review by the IRB Chair or a designee on 10/9/2018. The IRB has determined that the research involves no greater than minimal risk and falls under the following expedited review category:

7. Research on:
(a) individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior), **OR**
(b) research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

This is to inform you that you may commence your project. Please note that this approval is granted through 10/8/2019.

This study will automatically become inactive when its approval expires on 10/8/2019 *unless* a continuing review submission is approved by the IRB before that date. The IRB requires that you submit an application for continuing review at the end of each approval period and/or at study completion. ***It is the PI's responsibility to submit the application for***

continuing review and the appropriate IRB forms with adequate time for review and approval prior to the expiration date.

Any investigator whose project is externally funded must submit the applicable sponsor grant or contract for review and approval by the appropriate sponsored research office of the recipient institution (GU or MHRI). The project cannot proceed without the approval of the sponsored research office.

The International Committee of Medical Journal Editors (ICMJE) has established a requirement for registration of clinical trials in a public registry prior to enrollment as a condition of consideration for publication. Georgetown University has established a central registration process through the National Library of Medicine's Clinical Trials Protocol Registration System (PRS) known as ClinicalTrials.gov. Please contact the GU PRS administrator, Patricia Mazar, by e-mail at mazarp@georgetown.edu to set up a PRS user account to register clinical trials. The e-mail should contain the principal investigator's full name, department, phone number, and e-mail address.
Additional information may be found at http://ora.georgetown.edu, http://clinicaltrials.gov/, and at http://www.icmje.org/clin_trialup.htm.

For all Department of Defense (DoD) sponsored research, please note that you must obtain approval from the DoD human subjects committee as well as the local IRB before commencing this project.

** If promotional advertisements will be used for patient recruitment, they must be submitted for IRB review and approval prior to their use.

** Any incentives for participation in research are subject to IRB review and approval as well.

Please remember to:

1. Seek and obtain prior approval for any modifications to the approved protocol.
2. Promptly report any unexpected or otherwise significant adverse effects encountered in the course of this study to the IRB within seven (7) calendar days. This includes information obtained from sources outside GU or MHRI that reveals previously unknown risks from the procedures, drugs, or devices used in this study.

Georgetown University IRB
Medical-Dental Building, SW104
3900 Reservoir Road NW
Washington, DC 20057
(202)687-1506 *telephone*
(202)687-4847 *facsimile*

Annex 5: List of stakeholders interviewed or 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	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
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	ICTJ-Kenya

Annex 6: List of supporting documents reviewed

Relevant national strategy documents

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

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).

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 Canada. 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.

Mishori R, Anastario M, Naimer K, Varanasi S, Ferdowsian H, Abel D, Chugh K (2017). mJustice: Preliminary Development of a Mobile App for Medical-Forensic Documentation of Sexual Violence in Low-Resource Environments and Conflict Zones. Glob Health Sci Pract. Mar 28;5(1):138-151. Doi: 10.9745/GHSP-D-16-00233. Print 2017 Mar 24.

Ferdowsian H, Kelly S, Burner M, Anastario M, Gohlke G, Mishori R, McHale T & Naimer K. (2016). Attitudes Toward Sexual Violence Survivors: Differences Across Sectors in Kenya and the Democratic Republic of the Congo. J Interpers Violence. Mar 27. Doi: 10.1177/0886260516639257.

Ferdowsian, H., Mishori, R., & Naimer, K. (2016, Jan). Prosecuting Sexual Violence in Conflict: A medical approach. Angle Journal. Retrieved from http://anglejournal.com/article/2015-12-clinicians-in-the-prosecution-of-conflict-related-sexual-violence/

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.

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

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

Naimer K, Brown W, and Mishori R (2017). MediCapt in the Democratic Republic of the Congo: The Design, Development, and Deployment of Mobile Technology to Document Forensic Evidence of Sexual Violence. Genocide Studies and Prevention. Volume 11, Issue 1, Article 6.

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.

Annex 7: CV of evaluators

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