Integrating the PEPFAR Technical Considerations into Health Services to Improve the Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence in Kenya: Final Report

August 2015

IntraHealth International: Capacity*Plus* and FUNZO Kenya Projects

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ACKNOWLEDGEMENTS

We wish to thank the Ministry of Health (MOH) in Kenya for being very receptive to work with the OHA Gender TWG activity. We acknowledge the big achievement, limited funding notwithstanding, represented by the integration of the PEPFAR Technical Considerations into the national training curriculum for service providers in Sexual and Gender Based Violence (SGBV). For the first time ever in Kenya, we have a module dedicated to children and adolescents within the national curriculum. We acknowledge the leadership of Dr. Bartilol Kigen, Head of the MOH's Reproductive Maternal Health Services Unit (RMHSU), in the process. We are indebted to Dr. Anne Ng'ang'a, SGBV Program Manager at the RMHSU, for her technical leadership and coordination of partners during the implementation process. These efforts ensured synergy was maintained between partners and resources were spent wisely particularly between the FUNZOKenya Project and the SGBV Networks.

It is important to note that this activity was a joint effort involving the USAID-funded and IntraHealth International-led Capacity*Plus* and FUNZOKenya Projects, the MOH through the RMHSU, departments of health in six counties—Tharaka Nithi, Embu, Meru, Kitui, Machakos and Makueni—and service providers who participated throughout the activity. APHIA*Plus* Kamili Project provided invaluable support during the training needs assessment and post training follow up.

We recognise FUNZOKenya staff for providing overall leadership in the implementation of the activity, i.e., the development of the supplemental training materials for children and adolescents. These materials are now part of the new module within the revised national curriculum. This is a major milestone since such a module did not exist before this activity. We specifically acknowledge Peter Milo for providing project management leadership and Peter Shikuku for the curriculum development expertise. The following staff also provided invaluable field and county-based coordination during training needs assessment, material development and post-training follow up: Judith Karia, Ian Wanyoike, and Janet Makena. Additionally, we recognize Stella Gitia and Dorothy Mwatha from APHIA*Plus* Kamili for their active involvement in the needs assessment, module development and continued post training follow up at the health facility level past the activity's implementation period. Capacity*Plus* and FUNZOKenya projects bank on APHIA*plus* Kamili and the county MOH from the six counties to continue mentoring and supporting service providers trained using this improved curriculum. We appreciate the technical support from Constance Newman, Dr. Alfredo Fort, and Alex Collins of Capacity*Plus* for their overall technical assistance, specifically in developing the assessment tools, providing guidance during implementation, and interphasing with USAID and WHO in providing progress updates and maintaining visibility of the activity in Kenya. We extend our appreciation to Carolyne Ajema, SGBV Consultant, for her invaluable contributions in conducting the desk review that informed the activity implementation.

IntraHealth International in Kenya looks forward to more collaborative work in SGBV with the MOH's RMHSU, county MOH and development partners including APHIA*plus* and others.

Sincerest thanks,

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BACKGROUND

With approximately 160,000 children and youth living with HIV in Kenya and an estimated adult prevalence of 5.3%, the government is seeking to reduce HIV risk factors, including those associated with sexual and gender-based violence (SGBV). Sexual violence against children and adolescents has been linked to immediate and long-term health consequences, including increased risk for sexually transmitted infections (STIs) such as HIV, unwanted pregnancy and complications during pregnancy, increased rates of alcohol and drug use, and mental health issues such as clinical depression, post-traumatic stress disorder, and suicide. A Violence against Children (VAC) Survey carried out in Kenya indicates that sexual violence is widespread for both sexes, with 32% of females and 18% of males reporting an experience of sexual violence during their childhood (Government of Kenya and Ministry of Gender, Children and Social Services 2012). Gender and societal factors such as low social status, particularly for girls, economic dependence, and level of physical and emotional development can lead children to be to frightened, ashamed or unable to disclose abuse, making specialized training and care for these cases a true need (Day & Pierce-Weeks 2013). In Kenya, less than 10% of those individuals who experienced sexual, physical, or emotional violence as a child reported receiving professional care and there is little documentation of the extent to which existing services in Kenya are responsive to the needs of children and adolescents who report to health facilities after an incident of SBGV.

The medical treatment regulations for Kenya's Sexual Offences Act require all doctors, nurses, and clinical officers to be able to offer the post-rape package of care to survivors of sexual violence in health facilities. Through the Ministry of Health (MOH), the government of Kenya (GOK) has developed national guidelines on management of survivors of sexual violence and a clinical training manual for health providers, but these guidelines fail to stipulate how to make services responsive to the specific needs of child and adolescent survivors. It is not clear to what extent health workers are equipped with appropriate skills to provide standardized, quality, and comprehensive services to this special population, nor have all health providers taken the MOH training on clinical management of survivors of sexual violence or express feeling competent to manage child and adolescent survivors.

Within this context, the Office of HIV/AIDS (OHA) Gender Technical Working Group invited Capacity*Plus* to apply its expertise in health worker training and performance support to improve health system response to children and adolescents who have experienced sexual violencein Kenya. In collaboration with USAID's FUNZOKenya health worker training project and its APHIA*plus* Kamili service delivery project, Capacity*Plus* supported the MOH's Reproductive and Maternal Health Services Unit (RMHSU) in revising the national SGBV curriculum to reflect recent changes in national policy guidelines on the management of sexual and gender based violence in Kenya. Specifically, Capacity*Plus* and FUNZOKenya (referred to as "the projects"), along with other key government stakeholders and implementing partners, assisted the RMHSU to develop a new training module focused on the clinical management of children and adolescents, which was missing in the national curriculum, including supplemental training and performance support materials (originally conceived as a "package"), based the AIDSTAR-One publication, "The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs" (hereafter referred to as the "PEPFAR Technical Considerations"). Sections in the new module and wider curriculum address HIV counseling and testing (as well as pregnancy testing and counseling), plus post-exposure prophylaxis, referrals, and forensic examinations.

To inform the development of the new training module and supplemental training and performance support materials, Capacity*Plus* conducted a desk review of national policy and service protocols on the response to children and adolescents experiencing sexual violence in Kenya, as well as a training

needs assessment among GBV-trained providers and trainers. IntraHealth also tested the effectiveness of the new training module and supplemental materials among a small sample of GBV-trained providers and trainers. More details on the methodology, design/start up and implementation of the activity can be found in the following sections. The revised national SGBV curriculum now officially includes this new module on children and adolescents and will be finalized and released later in 2015 as the MOH's RMHSU seeks to fulfill its mandate to train health care workers on management of all survivors of sexual violence, including children and adolescents.

Table 1: List of Products Developed by the MOH's RMHSU, with support from FUNZOKenya and Capacity*Plus*

Title	Type/description of product
Revised National SBGV Curriculum	Facilitator's Manual
New Training Module on Management of Children and Adolescents who have Experienced Sexual Violence	Unit 1: Key Principles for Working with Children and Preparation for Management of Children and Adolescents
	Unit 2: History Taking
	Unit 3: Physical Examination and Psychological Assessment
	Unit 4: Investigation and Forensic Management
	Unit 5: Treatment and Counselling
	Unit 6: Follow up Care and Referral
Supplemental Training and Performance Support Materials	Clinical Site Preparation and Set-Up Checklist, Job Aid, Annex 6[1]
	Forensic Specimen Evidence Collection Job Aid
	Care Algorithm for Child and Adolescent Survivors of Sexual Violence[2]
	Referral Algorithm for Children and Adolescents
	Tanner Stages of Sexual Maturation Tool

METHODOLOGY

This activity had four key components:

1. **Stakeholder consultative meetings.** These meetings were held at the national level with the MOH's Reproductive and Maternal Health Services Unit (RMHSU). The purpose of these meetings was to secure buy in towards development of a supplemental training and performance support materials to strengthen service providers' knowledge and skills in clinical management of child and adolescent survivors (See Appendix 1 for a list of key stakeholders).
2. **Desk review of existing national,regional and international standards on the management of sexual violence**. This review was conducted to determine extent to which services are customized to

[1] This checklist was was adapted for all modules of the revised national curriculum to facilitate set up of SGBV sites.
[2] Workshop participants found the care algorithm included in the PEPFAR Technical Considerations to be confusing for the Kenyan context because of the hours indicated before examination and contamination of evidence for rape; instead the ECSA algorithm was found to be more appropriate and tailored to the local setting.

respond to child and adolescent survivors of sexual violence. Materials were reviewed using the PEPFAR Technical Considerations as a benchmark.

3. **Training needs assessment on service provider attitudes, knowledge, skill and resources for clinical management of child and adolescent survivors of sexual violence.** The projects, in collaboration with APHIA*plus* Kamili, conducted this assessment in 18 public health facilities and used results to identify any provider performance gaps that could be addressed with supplemental materials.
4. **Curricula review and development workshops.** The RMHSU convened three workshops to review and revise the current national SGBV curriculum with participants from various government departments, non-governmental organizations (NGOs) and private and public health facilities. The first workshop focused on identifying gaps in the national curriculum and producing a first draft of the revised training program and course schedule, while the second workshop delved into the content of the new module on children and adolescents and the third was dedicated to validating all of the draft modules as a whole. The workshops were organized with technical and financial support from the projects and using principles from IntraHealth's Learning for Performance (LFP) instructional design approach (IntraHealth International 2007). This approach to training design targets performance problems or gaps where workers lack the essential skills and knowledge for a specific job responsibility, competency or task. The LFP approach combines experience in two key areas, performance improvement and instructional design, and can be used to develop learning interventions of any scale (IntraHealth 2007).

Design and start up phase

Meetings with high-level stakeholders

The projects held three meetings with high-level stakeholders in preparation for reviewing the current national curriculum and developing the supplemental materials in line with the PEPFAR Technical Considerations. The purpose and key outcomes of each meeting are described below.

FUNZOKenya first met with the MOH's RMHSU on September 26, 2014. The purpose of the meeting was to orient MOH officials to the PEPFAR Technical Considerations and to solicit their support for the OHA initiative to integrate these international guidelines and tools into the national curriculum through the development of a supplemental package of training and performance support materials for health workers. Outcomes of the first meeting included consensus on the following:

1. **That gaps in SGBV response for children and adolescents in many countries resonated with the Kenyan experience.** There was concurrence on the need to strengthen the current national SGBV training curriculum to effectively address the needs of children and adolescents.
2. **That the current curriculum was too general and not specific to any target group**. Its generalist nature made it less effective in preparing SGBV providers to sufficiently address the needs of child and adolescent survivors of sexual violence.
3. **That the current curriculum was too theoretical**. A reliance on theory rather than on a performance-oriented approach lessened the curriculum's effectiveness in supporting attainment of clinical and forensic skills and competencies required for quality SGBV service provision.
4. **That existing guidelines for the clinical management of sexual violence could be strengthened in relation to the specific needs of children and adolescents.** Use of the

PEPFAR Technical Considerations in revising the current curriculum could provide plausible, international guidance on how to respond specifically to this special population.

5. **Forensic evidence collection and transmission to police and the judiciary were also considered areas in need of improvement**. Systemic and infrastructural challenges were seen to hinder effective chain of custody of evidence and protection and justice for survivors (Kenya National Commission on Human Rights 2012).

The national-level stakeholders resolved that, to mitigate these challenges, there was need for full stakeholder consultation in the curriculum review process, as well as wider evaluation of clinical guidelines and strengthening links with other sectors.

To continue driving this process, the RMHSU convened a second meeting on September 30, 2014 to develop a list of stakeholders who should be involved technically and financially in the revision of the national SGBV curriculum. A group of stakeholders already supporting SGBV responses in Kenya, drawn from the public, private, and NGO sectors as well as international development partners were identified as key to this process (see Appendix 1 for list of key stakeholders). Before being approached by FUNZOKenya and Capacity*Plus*, the MOH's RMHSU had already been planning to review its curriculum with the support of the SGBV networks. The FUNZOKenya team seized this opportunity to introduce the PEPFAR Technical Considerations as a key resource for the curriculum review, which resulted in the RMHSU deciding that rather than develop a supplemental package of training and performance support materials, that these materials be integrated into the revised curriculum in the form of a new module specifically addressing clinical management of children and adolescents.

A third meeting was held by FUNZOKenya with APHIA*plus* Kamili project staff on October 24, 2014 to introduce their field staff to the PEPFAR Technical Considerations and seek the project's collaboration in conducting a training needs assessment among providers in the region who had participated in the SGBV TOT training supported by FUNZOKenya in October 2012. Major outcomes of this meeting included:

- **Commitment by APHIA*plus* Kamili to identify previously-trained providers and assist with training needs assessment among those providers who will be trained using the new module and supplemental materials.** Many of the providers trained at the 2013-2014 TOT had not been followed up and several had not attended to SGBV cases for various reasons such as promotion to other roles and transfer to other hospital departments.
- **Agreement that APHIA*plus* Kamili to take on the key role of liaising with the county-level MOH**. This role would be key to achieving the release of selected trainees for participation in training needs assessment and in piloting of the new training module and supplemental materials. From their experience in the region, APHIA*plus* staff had observed the following skills gaps among health workers practicing SGBV with children and adolescents: trauma counseling, medical examination of children, and providing age-specific counseling.

Desk review and development of a training needs assessment tool

The desk review was undertaken by a local consultant with expertise in SBGV and curriculum development. With guidance from FUNZOKenya and Capacity*Plus* technical staff, the consultant conducted a systematic review of published and relevant sexual violence policies and guidelines, in Kenya, regionally, and internationally, as well as existing curricula in country. The objectives of the desk review were as follows:

- Establish the extent to which existing SGBV policies, guidelines, and training manuals include material on how to respond and manage cases of sexual violence experienced by children and adolescents
- Identify gaps, such as in content, knowledge, skills and/or attitude objectives in national SGBV curricula as related to clinical management of child and adolescent survivors of sexual violence
- Formulate recommendations on how to integrate content from the PEPFAR Technical Considerations into national level SGBV curriculum

The desk review highlighted the need for specific guidance on children and adolescents in national guidelines for clinical management of sexual violence and the lack of a training module focusing on this special population in the national SGBV curriculum. Findings from the desk review were used to make recommendations to the RMHSU for the curriculum review workshops and for the design of the training needs assessment tool to be implemented with a sample of service providers who had already been trained in SGBV. The complete desk review can be found in Appendix 2.

Implementation of a training needs assessment among service providers

FUNZOKenya and APHIA*plus* Kamili project team members administered the training needs assessment tool among 30 service providers in 18 public health facilities located in 5 counties: Kitui (4 facilities), Tharaka Nithi (3 facilities), Meru (5 facilities), Embu (5 facilities) and Makueni (3). Providers targeted for this assessment were those who had participated in a SGBV training of trainers workshop organized by FUNZOKenya in 2012 in the sampled facilities. Results of the training needs assessment, as well as the desk review, were used to develop the curriculum review workshop objectives and to inform development of the supplemental training and performance support materials. Key assessment results included:

- Weak health worker technical capacity and lack of equipment/supplies to conduct forensic examinations (e.g., genital/anal and head-to-toe) of child and adolescent survivors;
- Lack of supervision among health workers to to improve their performance (70% had not received supervision in the last 6 months);
- Turnover of trained providers to areas where they rarely interact with cases of SGBV and thus cannot apply what they have learned;
- Need for clinical response to child and adolescent survivors to be embedded in a multi-sectoral response to SGBV.

The full training needs assessment report, including the assessment instrument, can be found in Appendix 3.

Implementation phase

Curriculum review workshops

To review the current SGBV curriculum and determine the timeline and process for making revisions, the MOH's RMHSU convened an initial workshop from March 24-27, 2015, drawing participants from various government departments, non governmental organizations and both private and public health facilities. At this workshop, FUNZOKenya was invited to present on two major topics: 1) making the health system more responsive to children and adolescents who have experienced sexual violence through an overview of findings from the training needs assessment and 2) the role of service and clinical management standards in instructional design, during which presentation

attendees were oriented to the PEPFAR Technical Considerations, Intrahealth's LFP approach as well as other key SGBV resources. Over the course of the workshop, FUNZOKenya staff facilitated sessions on training content analysis, identifying training gaps, and designing training programs and course schedules, all based on the LFP approach that goes beyond assessing service provider competency to include the work environment as important element in determining health worker performance. For example, following this approach the identification of content and development of competency-based/performance-oriented training objectives was preceded by a discussion of the tasks required to perform SGBV services and competencies were teased out of the identified tasks. Participants also learned how workplace barriers and constraints must be addressed alongside service provider competency for quality service provision. By the end of the workshop, participants had identified gaps in current SGBV training and practice, reached a consensus on the tasks, functions and competencies for SGBV service providers, and completed a draft training program and course schedule to meet the requisite competencies for quality clinical management of SGBV. Based on the draft training program, smaller working groups were assigned to each course module to continue developing the training materials.

With leadership from the RMHSU, Capacity*Plus* and FUNZOKenya helped to organize a second workshop to spearhead the design of the new training module focused on clinical management of children and adolescents who have experienced sexual violence. The decision to develop this module was reached at the first workshop where findings from the training needs assessment and review of the existing training materials reinforced the need for specific training materials focused on this special population. Held from April 20-24, 2015, 32 representatives from the MOH, FUNZOKenya, APHIA*plus* Kamili, LVCT, Nairobi Women's Hospital, and Physicians for Human Rights (PHR) participated in workshop sessions to develop the schedule, content, job aides and service provision protocols, and assessment tools for the six-unit, full-day module. The table below summarizes the materials integrated into the new module with an indication of the source from which each was adapted (See Appendix 4 for the new training module).

Table 2: Clinical Management of Children and Adolescent Module for National SGBV Curriculum – Module Units and Tools Adapted to Kenyan Context and Established Protocols

Module Units and Tools	Source
Unit 1: Key Principles for Working with Children and Preparation for Management of Children and Adolescents	PEPFAR Technical Considerations, "Guiding principles for medical providers working with children who have experienced sexual violence and exploitation," pages 6-10
Unit 2: History Taking	PEPFAR Technical Considerations, "Taking a medical forensic history," pages 30-32
Unit 3: Physical Examination and Psychological Assessment	PEPFAR Technical Considerations, "Psychological assessment," "Physical and anogenital examination," and "Evidence collection in acute sexual assault," pages 32-43
Unit 4: Investigation and Forensic Management	PEPFAR Technical Considerations, "Psychological assessment," "Physical and anogenital examination," and "Evidence collection in acute sexual assault," pages 32-43
Unit 5: Treatment and Counselling	PEPFAR Technical Considerations, "Interpretation of clinical findings," "Sexually transmitted infections in children," "Emergency contraception," and "Injury treatment," pages 44-50
Unit 6: Follow up Care and	PEPFAR Technical Considerations, "Psychosocial interventions,

Module Units and Tools	Source
Referral	follow-up care, and referrals," pages 53-57
Clinical Site Preparation and Set-Up Checklist, Job Aid, Annex 6[3]	PEPFAR Technical Considerations, "Clinical site preparation and set-up job aid," pages 75-76
Forensic Specimen Evidence Collection Job Aid	Adapted from from WHO Guidelines on Medico-Legal Care for Victims of Sexual Violence, page 59
Care Algorithm for Child and Adolescent Survivors of Sexual Violence[4]	Adapted from from Guidelines for the Clinical Management of Child Sexual Abuse, East, Central and Southern African Health Community, page 29
Referral Algorithm for Children and Adolescents	PEPFAR Technical Considerations, "Provider's role in linking to community resources job aid," page 113
Tanner Stages of Sexual Maturation	PEPFAR Technical Considerations, "Tanner stages of sexual maturation," pages 73-74

Following IntraHealth's LFP approach, participants undertook a task/functional analysis during the second workshop to tease out the various tasks required of practitioners who provide SGBV services including to children and adolescents, with participants divided into seven groups representing different counties: Machakos, Kitui, Makueni, Tharaka Nithi, Embu, Meru, and Nairobi. Specific tools from the LFP approach, such as Tool 3: Performance Factors Worksheet, were used for the task analysis; participants requested to also use these tools to assess the status of services at their facilities/counties. This analysis led to the development of the different checklists to assess service provider competence in provision of SGBV services to children and adolescents, job aides/service provision protocols to assist in effective service provision, pre- and post-test questions for the module, and a detailed course schedule. A full report from the second curriculum review workshop and participant list can be found in Appendix 5.

In addition to these child- and adolescent- specific materials, the projects also contributed to the development of observed practice guidelines for a SGBV practicum to be included in the revised national SGBV curriculum. These observed practice guidelines (or practicum sessions) are intended to reinforce providers' practical skills in comprehensive management of survivors, namely history taking, physical examination, psychosocial and psychological assessment, forensic evidence management, documentation and referrals after they have completed the national SGBV training. These observed practice guidelines can be found in Annex 3 of the complete draft facilitator's manual.

Finally, the projects participated in a RMHSU-led validation workshop on July 7, 2015 to review the revised national SGBV curriculum, compiled in a draft facilitator's manual, in its entirety and contribute final comments and feedback before RMHSU pilot testing. At this meeting, the new module on children and adolescents was accepted as part of the draft national SGBV curriculum, representing a major achievement in the integration of the PEPFAR Technical Considerations and institutionalization of the new training module for children and adolescents (see Appendix 6 for invitation letter to validation meeting). The RMHSU intends to integrate feedback from the

[3] This checklist was was adapted for all modules of the revised national curriculum to facilitate set up of SGBV sites.
[4] Workshop participants found the care algorithm included in the PEPFAR Technical Considerations to be confusing for the Kenyan context because of the hours indicated before examination and contamination of evidence for rape; instead the ECSA algorithm was found to be more appropriate and tailored to the local setting.

validation meeting and pilot testing results into the final published edition which is scheduled for release in September 2015.

Pilot application of the curriculum module on children and adolescents

FUNZOKenya and Capacity*Plus* led a pilot application of the new curriculum module, including use of the supplemental training and performance support materials, with a group of 15 service providers and 3 trainers linked to APHIA*plus* Kamili and offering SGBV services in Lower and Upper Eastern regions of Kenya. The pilot application was intended to assess the:

1. Appropriateness and relevance of training content in supporting development of competencies for SGBV service provision for children and adolescents
2. Effectiveness of training methodology for imparting needed skills and use of the Learning for Performance /competency-based approach
3. Adequacy/sufficiency of time allocated for each content area
4. Organization, sequencing of content for training
5. Adequacy/relevance/quality of supplemental training and performance support materials – handouts, job aides, checklists, etc. – for continued follow up and on-job mentorship of providers and trainers and for enhancement of service provision

Over the course of three days, three trainers drawn from the group of service providers trained at the FUNZOKenya-led SGBV TOT in 2012 implemented the new training module with 12 participants, using the draft facilitator's manual and supplemental materials (see Appendix 7 for report on the pilot application). Based on post-test results, the majority of participants responded that the training content met their needs, i.e., supported development of competencies for SGBV service provision to children and adolescents. The training methodology was also rated highly, with 67% of trainers and 82% of the participants reporting that it was very effective in building skills in clinical management of this special population. Service providers also expressed increased comfort in their level of knowledge and/or experience managing cases of child or adolescent sexual violence (93.3% to 100%) and—more critically—with performing child and adolescent forensic exams for male and female patients (48% to 100% and 62% to 90%, respectively). Regarding the organization, sequencing and time allocated for each content area, trainers found all of these areas to be adequate, whereas participants expressed a desire for more training time.

The majority of the participants (64%) felt that the supplemental training and performance support materials (included as appendices in the new curriculum module) were adequate, relevant, and of good quality to continue follow up and on-the-job mentorship of providers and trainers to enhance service provision to child and adolescent survivors of sexual violence. A further third (33%) of participants agreed that the supplementary materials were of good quality but that more time was needed to develop the requisite skills, hence the need for further on-the-job training and mentorship. A video was used to demonstrate the skills of obtaining consent, history taking, physical examination, collection of forensic evidence and documentation. Some of these skills, like examination and collection of forensic evidence, were done via demonstration due to lack of mannequins. In response to this finding, the FUNZOKenya staff made arrangements with APHIA*plus* Kamili to follow up with participants to conduct practicum sessions using the observed practice guideliens and further support their acquisition of these practical skills.

ACHIEVEMENTS

Throughout the design/start up and implementation phase of this activity, the projects made important achievements related to the integration of the PEPFAR Technical Considerations into health services to improve the clinical management of children and adolescents who have experienced sexual violence in Kenya. In keeping with the intention of the PEPFAR Technical Considerations to act as a starting point, these achievements in Kenya demonstrate how the MOH, NGOs, public and private sector health facilities and clinicians have begun to adapt them for national use and in line with national guidelines and laws. Major achievements are described in more detail below.

1. **Engagement of stakeholders across sectors in curriculum review process.** The curriculum review process brought together decision makers, content experts and practitioners from government, private and NGO sectors. It was led by the MOH's RMHSU with technical and meeting facilitation support from FUNZOKenya staff. Multi-sectoral representation in the process helped with early acceptance of findings from the desk review and training needs assessment and recognition of the need for child and adolescent-specific training materials for health workers providing SGBV services. Ownership of the revised curriculum is now felt across sectors and should support its dissemination and sustainability.
2. **Use of desk review and training needs assessment results by MOH to inform curriculum review process.** The timing and scope of the desk review and training needs assessment coincided with the RMHSU's need for data to inform their decision making during the curriculum review process. By reviewing existing training materials as well as national policies, guidelines and protocols related to SGBV in Kenya, the projects were able to make a case for the use of the PEPFAR Technical Considerations as a key resource for the curriculum review and the new module focused on children and adolescents. By not only assessing service provider knowledge and performance gaps in the training needs assessment, but also including questions on service provider attitudes and values surrounding about sexuality and gender, the projects found interesting results, such as a third of male respondents agreeing that "adolescents are too young to be asking for the use of contraceptives". As a result of such findings, the national SGBV curriculum is also adding a unit on "self-exploration/self-awareness on gender issues within the first module to address provider perception and attitudes in order to align them to rights and choice.
3. **Introduction of new module on clinical management of children and adolescents into revised national SGBV curriculum.** Most importantly, FUNZOKenya and Capacity*Plus* took the RMHSU's invitation to participate in the curriculum review process as an opportunity to orient key stakeholders to the PEPFAR Technical Considerations and advocate for the creation of a child and adolescent-focused module that would address gaps identified in current training and assessed among service providers. The draft module on management of sexual violence in children and adolescents uses the PEPFAR Technical Considerations as its main reference; many of its job aids and checklists were adapted to the Kenyan context to form the supplementary materials to support training and performance included as annexes in the module and for the entire curriculum. At this time, the MOH supports the inclusion of these supplemental materials in the facilitator's guide to be published in September 2015.
4. **Integration and institutionalization of the PEPFAR Technical Considerations.** Capacity*Plus* and FUNZOKenya took a consultative, capacity-building approach which

resulted in the integration of the PEPFAR Technical Considerations into the new training module and supplemental training and performance support materials, which are now also part of the national SGBV curriculum.

5. **Promotion of practicum sessions and observed practice guidelines to support service providers and their supervisors the acquisition of required compentencies.** From the beginning, stakeholders recognized the theoretical focus of the national SGBV curriculum as a weakness. In the revised national SGBV curriculum, observed practice guidelines were developed to support practicum sessions and mentorship in acquiring required competencies for clinical management of child and adolescent survivors of sexual violence. Certificates of competence will now only be issued to service providers demonstrating competencies in all of the tasks after participating in the national SGBV training course.

CHALLENGES

The projects encountered some key challenges over the course of introducing the PEPFAR Technical Considerations and pursuing the development of supplemental materials to bolster the current national SGBV curriculum and improve service providers' competencies in clinical management of child and adolescent survivors of SGBV. First, upon initating the activity, the projects' staff learned that the RMHSU was already reviewing the national curriculum with the assistance of other implementing partners, making the development of a supplementary package feel like a parallel process to this major, ongoing activity. However, this discovery turned into an opportunity as the projects' staff were invited by the RMHSU to participate in the curriculum review process and it was deemed strategic and timely to embed the development of child and adolescent-specific materials into this process, resulting in a new module focused on this special population with supplementary training and performance support materials included throughout and as annexes. Secondly, achieving consensus among the myriad of partners supporting SGBV programs/projects in Kenya proved time intensive and challenging. However, the diversity of perspectives and range of experience brought by these partners were a resource for the team and enabled the development of different technical modules for the overall curriculum. Finally, the 12-month time frame for the activity (due to its application in the last year of the Capacity*Plus* project), which was further truncated by delayed approval to initiate field work, led to the elimination of some sub-activities from the workplan and constrained the projects' ability to test and disseminate the new module and supplementary materials more widely.

LESSONS LEARNED AND RECOMMENDATIONS

Overall, the experience of rolling out the PEPFAR Technical Considerations in Kenya, specifically through the revisions to the national SGBV curriculum, resulted in some important lessons and recommendations. Most critical to the projects' achievements was the involvement of government stakeholders from the earliest stages of the activity, which aided in mobilizing the most relevant and impactful players for the curriculum development and review process. The involvement of the MOH's RMHSU at every stage of the process also assured ownership and adoption of training materails by all involved and ensured that training was standardized. With such responsiveness from the MOH in Kenya, the projects were able to not only introduce but effectively integrate the PEPFAR Technical Considerations into the existing curriculum. Involvement of the MOH at the county level and of regional partner APHIA*plus* Kamili will also ensure continued support for trained service providers. The projects recommend that such collaboration at the national and county level be

replicated as much as possible for other contexts in which the PEPFAR Technical Considerations are integrated into health worker training.

Going forward, Capacity*Plus* and FUNZOKenya have formulated some key recommendations for the MOH, as it finalizes the revised SGBV curriculum and determines how/if to use the supplemental materials as part of the training program, and for USAID, as it seeks to roll out the PEPFAR Technical Considerations in other countries/contexts.

- **Additional support for building service provider capacity, as well as improving infrastructure and equipment, will be needed to ensure effective provision of SGBV services to children and adolescents.** In Kenya, health facilities at the county level have few providers trained and competent to respond to children and adolescents who have experienced sexual violence, and required infrastructure and equipment is limited for managing these cases. There is a need to train more service providers on SGBV (including improvement of attitudes towards these populations), but only if sites are equipped to provide SGBV services, and if the larger referral system for this type of care is strengthened.
- **Further adaptation of supplemental training and performance support materials to country context could be a valuable investment.** Participants responded favorably to supplemental training materials, such as care algorithms and job aides, based on the PEPFAR Technical Considerations that were adapted to country context. Investing in adapting additional materials, such as videos demonstrating the SGBV response skills in a local setting, would make the PEPFAR Technical Considerations more easily accessible and understandable to participants.
- **Use of mannequins should be considered to facilitate learning and mastery of practical skills in medical examination and collection of forensic evidence.** Having access to these types of training devices supports skills building and can be used for observed practice and on-the-job refresher training.
- **The revised national SGBV curriculum and supplemental training and performance support materials should be disseminated at the national and county level.** There is a real need to sensitize county health officials in addition to national level MOH officials on changes to the national SGBV curriculum which will support ease in uptake of these documents by counties.

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APPENDIX 1. LIST OF KEY STAKEHOLDERS IDENTIFIED BY MOH'S RMHSU FOR SBGV CURRICULUM REVIEW

1. World Health Organization (WHO)
2. United Nations - UNICEF, UNFPA, UNWomen
3. Trocaire
4. DFID
5. USAID
6. CDC
7. Global Fund
8. Danida
9. GIZ
10. Physicians for Human Rights (PHR)
11. International Organization for Migration (IOM)
12. Sexual and Gender Based Networks (SGBV) supported by German Development Bank
13. Medecins Sans Frontieres (MSF)
14. Nairobi Women's Hospital, Gender Recovery Centre (GVRC)
15. Kenyatta National Hospital, Gender Recovery Centre (GVRC)
16. LVCT Health
17. Government Chemist
18. Judiciary
19. Kenya Police
20. National Aids Control Council (NACC)
21. MOH Forensic Division

APPENDIX 2. DESK REVIEW REPORT

Rollout of the PEPFAR Technical Considerations for the Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence

Part I: Desk Review: Existing Policy, Practice, and Training Guidance

May 2015

FUNZOKenya Project and
Capacity*Plus*, IntraHealth International

TABLE OF CONTENTS

ACRONYMS

ARV	Antiretroviral
EC	Emergency contraception
ECSA-HC	East, Central and Southern African Health Community
HVS	High vaginal swab
PEP	Post-exposure prophylaxis
PRC	Post-rape care
STI	Sexually transmitted infection
VAC	Violence against children
WHO	World Health Organization

Operational Definitions

Child:	Any person, male or female, under the age of 18. They are assumed to be limited in their ability to evaluate and understand the consequences of their choices and actions. In this assessment, a child refers to persons aged between 0-9 years.
Child sexual abuse:	The involvement of a child in a sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society (World Health Organization).
Adolescent:	Refers to persons between the ages of 10-19 years.
Sexual violence:	Any act described as an offence under the Kenya Sexual Offences Act. This includes, but is not limited to, rape, defilement, incest, child trafficking, child prostitution, and child pornography. This term has been interchangeably used with the term child sexual abuse.
Sexual violence against children:	All forms of sexual abuse and sexual exploitation of children.
Survivor:	A person who has experienced sexual violence.
Violence against children:	All forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.

BACKGROUND

Child and adolescent sexual abuse is a global social, human rights, and public health issue. "Child and adolescent abuse constitutes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (World Health Organization [WHO] 2012). Abuse can either be sexual, physical, and/or emotional. This desk review is focused on child and adolescent sexual abuse. "Child sexual abuse is evidenced as an activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust, or power, the activity being intended to gratify or satisfy the needs of the other person" (East, Central and Southern African Health Community [ECSA-HC] 2011).

Magnitude of Child Sexual Abuse

The WHO estimates that 150 million girls and 73 million boys experienced sexual abuse before attainment of 15 years (Krug et al. 2002). Of adolescents aged 15-19 years, 29.4% were cited to have experienced intimate partner violence (WHO 2013). Evidence shows that nearly a quarter of adults (22.6%) worldwide suffered physical abuse as a child; 36.3% experienced emotional abuse; and 16.3% experienced physical neglect (Stoltenborgh et al. 2012; Stoltenborgh et al. 2013). Lifetime child sexual abuse for girls and boys stands at 18% and 7.6% respectively (Stoltenborgh et al. 2011).

In Kenya, population-based data on the spread of child sexual abuse are limited. However, the Kenya Demographic and Health Survey of 2014 indicates 38% of Kenyan women aged 15–49 have experienced physical or sexual violence, including "forced sexual initiation." Data from a study conducted in Western Kenya showed that 50% of sexual abuse survivors seen at an outpatient department were children below 14 years (Ranney et al. 2011).

Sexual violence in Kenya is common (Waki Commission 2008). A study by the Population Studies and Research Institute among 454 Kenyan children indicated that 33 of them had experienced their first sexual encounter at less than 10 years, and 69 of them between the ages of 11 and 14 (Okumu et al. 1994). According to the African Network for the Prevention and Protection against Child Abuse and Neglect, 7.6% of children surveyed (n=501) from both rural and urban areas indicated having been "sexually abused" (ANPPCAN 2000).

A study on violence against children (VAC) carried out in Kenya indicated that at least 32% of females and 18% of males reported experiencing sexual violence during their childhood (Government of Kenya and Ministry of Gender Children and Social Services 2012). Health facility data point to a high number of children reporting for sexual violence management services in these contexts. From 2011-2012, for instance, the Nairobi Women's Gender Violence Recovery Centre recorded 2,532 cases of sexual violence, with just over half of these being of girls less than 18 years of age (Gender Violence Recovery Centre 2012). The VAC study revealed that less than 10% of females and males who experienced sexual, physical, or emotional violence as a child received professional care.

Risk Factors for Child/Adolescent Sexual Abuse

Several factors contribute to the sexual abuse of children and adolescents. These include their age, gender, and cultural context. Research shows girls as being more vulnerable to abuse than boys (Sedlak et al. 2010). Furthermore, children aged 7 and 13 are most vulnerable to sexual abuse (Finkelhor 1994). Risk factors for sexual violence transcend boundaries and can occur at individual, family, and community levels. Contributory factors associated with child and adolescent sexual abuse include low socioeconomic status, weakened family and social ties, alcohol and drug use, little education, lack of safe and nurturing relationships/environments, family composition and dynamics, witnessing violence at home, poor child-parent relationships, and increased number of dependants. Implicit support for violence is also linked to cultural norms that promote "male dominance" (Fleming, Mullen, and Bammer 1997; Heise 2011; King et al. 2004; Sedlak 1997).

Consequences of child and adolescent sexual abuse are far reaching and have direct and indirect effects on the life of the child. Psychological effects include stress, disruption of normal development, helplessness, hopelessness, impaired trust, and self-blame (Briere and Elliott 1994; Erulkar 2004). There is therefore need for mechanisms to facilitate access to care by child and adolescent survivors of sexual violence. The basic elements of such care include clinical care (taking a detailed history of the incident, performing a thorough head-to-toe examination, providing treatment for injuries, providing prophylactic treatment, evaluating risks of STI/HIV infection and pregnancy, and providing psychosocial support); evidence collection (collecting evidence to support treatment and investigation, documenting evidence or samples obtained, storage and preservation of evidence) and referral in a multisectoral environment (for continued medical care, psychosocial support, legal aid or rescue services).

Clinical Management of Child and Adolescent Survivors of Sexual Violence

Management of cases of child and adolescent sexual abuse is heavily dependent on disclosure. However, the VAC study (2010) revealed that only 46% of females and 36% of males aged 18 to 24 who experienced childhood sexual violence prior to age 18 told someone about the sexual violence (Government of Kenya and Ministry of Gender Children and Social Services 2012). Out of these, only a few reported receiving services (such as from a clinic or NGO) for any incident of sexual violence. In spite of adolescents reporting for care either alone or in the company of their caregivers, child-friendly services were often not offered due to lack of trained providers to deliver various services required such as examination, management, documentation and referral of cases, resulting in inadequate care and support for children (Keesbury and Askew 2010).

Children and adolescents who have been sexually abused may be rejected by their family and community, and become stigmatized, hence the need for social acceptance and integration strategies. They require comprehensive care, and the health sector plays a critical responsive role. Health facilities should provide immediate and continued medical attention to survivors. However, evidence from this desk review shows many health care providers are not trained in the management of child and adolescent survivors of sexual violence. The extent to which public health facilities in Kenya are equipped with the requisite, "friendly" infrastructure for management of child and adolescent survivors is not well documented. It is also not clear on the extent to which children and adolescent survivors receive the basic package of care stipulated in Table 1 below.

Table 1: Minimum Package of Care for Survivors of Sexual Violence in Kenya

Facility Capacity	Minimum Standards for Clinical Management	Reporting/recording requirements for health facilities	Minimum capacity requirements at health facilities
All health facilities without a laboratory (public and private)	ÅManage injuries as much as possible ÅDetailed history, examination, and documentation (refer for high vaginal swab [HVS], post-exposure prophylaxis/emergency contraception [PEP/EC], sexually-transmitted infection [STI])	Å Fill in post-rape care (PRC) form in triplicate Å Maintain PRC register Å Ensure survivor gets a copy of the PRC form and takes it to the laboratory	ÅA trained nurse
All health facilities with a functioning laboratory (public and private)	ÅDetailed history, examination and documentation (including HVS) ÅIdeally, first doses of PEP/EC should be provided (even where follow-up management is not possible) ÅWhere HIV testing and counseling services are available, provide initial counseling	Å Fill in PRC form in triplicate Å Maintain PRC register Å Maintain laboratory register Å Referral to comprehensive PRC facility	ÅA trained nurse and/or clinical officer ÅA trained counselor (where counseling is offered)
All health facilities with HIV, ARV, or a comprehensive care clinic where adherence to ARVs can be monitored (comprehensive PRC services can be provided) (private and public health facilities)	ÅManage injuries as much as possible ÅDetailed history, examination, and documentation ÅProvide emergency and ongoing management of PEP ÅProvide EC ÅProvide STI prophylaxis or management ÅProvide counseling for trauma, HIV testing, and PEP adherence	Å Fill in PRC form in triplicate Å Maintain PRC register Å Maintain laboratory register Å Fill in PRC form to follow up management of survivors	Å 1 medical officer or clinical officer trained in ARV/PEP management Å 1 trained counselor (trauma, HIV testing, and PEP adherence counseling) Å Laboratory for HIV and hepatitis B testing Å Preservation of sperm from HVS specimen

In response to the needs of child and adolescent survivors of sexual violence, the US President's Emergency Plan for AIDS Relief (PEPFAR), in collaboration with the Together for Girls Partnership, developed "Technical Considerations" for the clinical management of children and adolescents who have experienced sexual violence (Day and Pierce-Weeks 2013). The technical considerations were developed through a consultative process incorporating specialized input by experienced providers and technical experts. The technical considerations build upon existing foundational resources, including the WHO's 2003 guidelines for medico-legal care for victims of sexual violence and the ECSA-HC Guidelines for the Clinical Management of Child Sexual Abuse (WHO 2003; ECSA-HC 2011). Countries are encouraged to adapt these considerations within their existing national service delivery protocols. Kenya is yet to adapt to these technical considerations, despite the fact that the majority of its cases of sexual violence involve children and adolescents.

Current Response to Sexual Violence Frameworks in Kenya

Article 28 of Kenya's Constitution stipulates that "Every person has inherent dignity and the right to have that dignity respected," while Article 29 (c) stipulates that "Every person has the right to freedom and security of the person, which includes the right not to be (c) subjected to any form of

violence from either public or private sources." In addition, the Government of Kenya has put in place the following policies and standards toward prevention and response to sexual violence:

Health sector

The Ministry of Health has put in place national guidelines on the management of sexual violence (Ministry of Health/Division of Reproductive Health 2009). According to these guidelines core components of a comprehensive response to sexual violence and exploitation include clinical evaluation, examination and documentation, HIV testing, HIV prevention through the use of post-exposure prophylaxis (PEP), pregnancy prevention through the provision of emergency contraception (EC), sexually-transmitted infection (STI) management, and counseling for trauma and referral for the ongoing well-being of survivors (Ministry of Health 2013, 2014b). This is in line with what is stipulated in various regional and international guidelines and curricula on management of survivors (Krug et al. 2002; UNFPA Asia Pacific Office 2010; WHO 2003, 2005).

National Trauma Counselors Training Manual and the *National Curricula on Clinical Management of Survivors of Sexual Violence* (Ministry of Health 2006a, 2006b): These provide a benchmark on how providers are to offer clinical and psychosocial support to survivors. However, these two curricula lack explicit sections on management of child and adolescent survivors. The training methodology used is mostly didactic and not experiential, and providers are therefore not well equipped to translate knowledge gained in how they manage child and adolescent survivors.

National Health Sector Standard Operating Procedures on the Management of Sexual Violence in Kenya (Ministry of Health 2014a): These procedures are aimed at guiding facility level service providers in the public and private sectors on the provision of comprehensive medico-legal care, linkages and psychosocial support to survivors of sexual violence.

Legal frameworks

These include:

- The Sexual Offences Act of 2006, which provides for the definition of various offences, and prevention and protection of all persons from unlawful sexual acts (Government of Kenya 2006)
- The Children's Act, 2001, which provides for the rights, protection, and care of children
- The Witness Protection Act, 2006, which provides for the protection of witnesses in criminal proceedings
- The Criminal Procedure Code
- The Evidence Act
- The Bill of Rights, as enshrined in the Constitution of Kenya, 2010.

RATIONALE FOR THE DESK REVIEW

With funding from the USAID Office of HIV and AIDS (OHA), the Capacity P*lus* and FUNZOKenya projects, both led by IntraHealth International, commissioned this desk review with the aim of providing guidance on how the PEPFAR technical considerations might be integrated within national sexual violence training curricula as a supplementary package.

The desk review assesses the adequacy of the existing national guidelines and clinical training manuals in responding to the needs of child survivors of sexual violence using the technical considerations as a framework of reference. This rapid assessment of existing national curricula was designed to:

- Establish the extent of integration of sexual violence response for children and adolescents in existing training manuals on clinical management of survivors
- Identify gaps (content, knowledge, skills, and attitudes) in current curricula related to clinical management of child and adolescent survivors of sexual violence
- Facilitate the integration of content from the technical considerations into county and national level gender-based violence curricula.

Methodology

This paper is based on a rapid review of existing curricula and guidelines that are designed primarily to facilitate clinical management of survivors of sexual violence, but which have a secondary aim of strengthening the management of child and adolescent survivors. The review was benchmarked on the provisions contained in the PEPFAR technical considerations. In addition, the review also made reference to existing international, regional, and national policies/guidelines on management of survivors of sexual violence and/or curricula on clinical management of survivors. Systematic reviews of relevant policies/guidelines and curricula were undertaken. Our search strategy relied on published sources. The inclusion criteria consisted of the following (See Table 2, below):

- Clinical management protocols for survivors of sexual violence
- Training curricula on the clinical management of survivors of sexual violence
- Management of children and adolescent survivors of sexual violence.

Documents reviewed included:

- The clinical management of children and adolescents who have experienced sexual violence: Technical considerations for PEPFAR programs (2013)
- WHO guidelines for medico-legal care for victims of sexual violence (2003)
- WHO clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons (2004)
- ECSA-HC guidelines for the clinical management of child survivors (2011)
- UNICEF and International Rescue Committee's Caring for Child Survivors of Sexual Abuse.

FINDINGS

The review findings are outlined in Table 2 below.

Table 2: Review of Existing National and International Service Standards and Protocols on the Clinical Management of Survivors of Sexual Violence

Document title	Year of publication	Author	Focus of review	Specific content for children and adolescents	Existing gaps
Kenya National Guidelines on the Management of Sexual Violence	3rd Edition-2014	Ministry of Health–Kenya	History taking and examination	Informed consent procedures for various age groups	General section on investigations to be carried out Step-by-step processes are not outlined in all sections, but instead reference is made to how adults are managed
				History taking	
				Head-to-toe examination	
				Genital anal examination for boys	
				Genital anal examination for girls	
			PEP	PEP regimen for children defined • Dosage • Schedule • Side effects management • Follow up schedule	
			STI management	Clearly outlined the regimen to be given • When it is given • Dosage against weight	
			Pregnancy prevention	Clearly indicates • When EC is to be given and to whom	The following are not well outlined for children and adolescents: • When to give EC • What considerations are to be made—e.g., how tanner staging can be used • Duration of • Age factor • Dosage • Does not outline pregnancy management/termination in the context of adolescents
			Body maps		None for children
			Hepatitis B		No mention on how this applies to children
			Follow up care of survivors		This is generalized for all survivors
Guidelines for the Clinical	2011	East, Central and Southern African Health Community	Chapter 2: Medical management of child sexual	• Indicators of abuse • Preparations for management of	While these guidelines indicate the services to be offered to child survivors,

Document title	Year of publication	Author	Focus of review	Specific content for children and adolescents	Existing gaps
Management of Child Sexual Abuse			abuse	child survivors • Consent procedures • History taking • Physical examination • STI diagnosis and treatment • HIV testing and PEP • Hepatitis B testing and prophylaxis • Pregnancy testing and management	the step by step processes are not well aligned No mention on how the different services can be provided to children of different age groups
			Chapter 3: Forensic examination and evidence collection	• Forensic evidence collection • Purpose of specimens • Forensic specimen collection techniques	
			Chapter 4: Psychological, social and community interventions		
			Follow up care and management		
Guidelines for Medico-Legal Care of Victims of Sexual Violence	2003	World Health Organization	Chapter 3: service provision for victims of sexual violence	Chapter 7: Child sexual abuse • Examination • History taking • Collection of medical and forensic specimens • Treatment (STIs, HIV, Pregnancy) • Follow up care	Each of the sections is well outlined. These ought to be customized to suit the Kenyan context with a focus on management of child and adolescent survivors
			Chapter 4: Assessment and examination of adult victims of sexual violence		
			Chapter 5: Forensic specimens		
			Chapter 6: Treatment and follow up care		
			Chapter 7: Child sexual abuse		
			Chapter 8: Documentation and reporting		
Training manual on clinical management of survivors of sexual violence	2005	Ministry of Health-Kenya	Content covered: • Unit 1: Sexual violence and the law • Unit 2: Comprehensive clinical care • Unit 3: Forensic examination and		Duration given to modules touching on management of children not stipulated The 8 hours allocated to the module on clinical management of both adults and children/adolescents is not sufficient

Document title	Year of publication	Author	Focus of review	Specific content for children and adolescents	Existing gaps
			collecting specimens • Unit 4: Counseling • Unit 5: Referral mechanisms • Unit 6: Registration and information management • Unit 7: Supervision for quality improvement • Unit 8: Monitoring and evaluation Targeted providers for the training: doctors, clinical officers, nurses, and laboratory personnel Duration of the training: 3 days Delivery of the training • Who trains • Methods used • Equipment used • Evaluation methodologies used • Observed practices—is this done? how do they evaluate skills?		No sessions outlined on skill building for providers engaged in management of child and adolescent survivors of sexual violence No job aids that are focused on child and adolescent survivors of sexual violence
The National Health Sector Standard Operating Procedures on the Management of Sexual Violence in Kenya	2014	Ministry of Health		No content on management of child and adolescent survivors of sexual violence	Does not clearly articulate how providers can adapt these standards to the management of children and adolescent survivors There is need for standard operating procedures on the clinical management of child and adolescent survivors of

Document title	Year of publication	Author	Focus of review	Specific content for children and adolescents	Existing gaps
					sexual violence
Clinical Care for Sexual Assault Survivors—Facilitator's Guide A Multimedia Training Tool	2008	International Rescue Committee	How to plan for a training Considerations to be made in direct patient care: • Receiving the Patient and Preliminary Assessment • Obtaining Informed Consent and Taking the History • Performing a Physical Exam • Treatment and Disease Prevention • Caring for Male Survivors • Caring for Young Survivors Mode of delivery: Diverse methods used including practicum sessions, role plays, case studies, and group discussions	Has a section on "Caring for Young Survivors" Clearly outlines • How to assess child abuse • Physical examination of children • How to collect specimens from children • Treatment considerations • Pregnancy prevention without relying on age alone • Mental health and treatment referrals	None for children This training guide could be adapted for the Kenyan setting with focus on: teaching methodology—content and skill based
Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian	2012	International Rescue Committee and UNICEF		Highlights the knowledge, attitude, and skill set required of providers engaged in child abuse management • Communicating with children • How to conduct child health assessment needs • Pregnancy prevention-time limit • HIV prevention-time limit • Management of injuries	Need to contextualize this for non-humanitarian settings. Focus to be placed on: • How to provide a safe and caring environment for young survivors of sexual assault within the Kenyan public health system infrastructure • How to gather important medical information from children

Document title	Year of publication	Author	Focus of review	Specific content for children and adolescents	Existing gaps
Settings					• Medical examination for child survivors • Treatment options for child survivors as per dosage outlined in Kenya national guidelines on management of sexual violence
Clinical Management of Rape Survivors	Revised Edition-2004	WHO	Management of rape within refugee settings and among internally displaced persons • History taking • Forensic evidence collection • Physical and genital examination • Treatment • Follow up care of survivor Checklist of needs for clinical management of rape survivors	Care for child survivors	Management of children has been generalized; however, Kenyan policy guidance on child and adolescent survivors to be customized to include provisions stipulated in this document

Summary of Gaps in Kenya's National Policy and Training Standards on Sexual Violence Management Compared With the Technical Considerations

The Kenya national guidelines on the management of survivors of sexual violence make reference to the management of children and adolescents with a focus on:

- **Informed consent:** Provision exists, but no mention is made of the importance of obtaining consent and assent from the child or adolescent.
- **History taking and examination of children and adolescents:** The guidelines do not highlight the key guiding principles providers should observe while managing children/adolescents. These include using a child/adolescent-centred approach to service delivery with an aim of promoting the interest of the child, involving children and adolescents in decision-making, guaranteeing them confidentiality, and avoiding any form of discrimination, among other key principles outlined in the technical considerations.
- **Investigations for clinical management:** These are not clearly outlined in the national guidelines on management of sexual violence and the training manual on clinical management of survivors of sexual violence. It is assumed that providers will use their discretion to determine the investigations to be carried out as per Annex 16 of the considerations.
- **Injury management**: The national guidelines on management of sexual violence fail to mention preference to be given to the provision of Diphtheria, Tetanus and Pertussis (DPT) vaccine for children aged below 7. The guidelines do not indicate what should be done in case injuries require surgical attention.
- **Pregnancy prevention and management**: No reference is made to Tanner Staging[5] and management of any pre-existing or resulting pregnancy following the sexual violation.
- **Evidence collection:** No mention is made of the duration within which forensic evidence must be obtained from child and adolescent survivors. Focus is also only made to the type of specimens that can be collected, and not the time within which certain types of evidence are viable or can be retrieved from a survivor's body.

The national training curriculum on clinical management of survivors of sexual violence is also limited in both adequacy of content and effectiveness of training methodology.

Content: The 8 hours allocated to the unit on management of children is not adequate to cover comprehensive management of adult and child/adolescent survivors of sexual violence. The following aspects are also lacking from the curriculum:

- Evidence collection for the pre-pubertal and pubertal survivors

[5] Tanner staging is used to define physical measurements of development based on external primary and secondary sex characteristics, such as the size of the breasts, genitals, testicular volume, and development of pubic hair.

- Job aids for obtaining informed consent, undertaking physical examination, evidence collection, body maps
- Interpretation of clinical and injury findings when managing children
- Psychological assessment of child and adolescent survivors
- Referral pathways for children and adolescents and available psychosocial support mechanisms
- Role of the provider in reporting of cases of sexual abuse.

Methodology: The national curriculum on clinical management of sexual violence does not emphasize use of case studies and practical sessions to enable trainees to develop practical skills and relate to the management of children and adolescents. While it has been designed to facilitate trainees to effectively translate knowledge gained to practice, no provision is made to allow for them to practice in a clinical setting and be observed as they attend to survivors who present in health facilities. It is therefore not possible to establish their competencies post training.

CONCLUSION

This paper highlights potential areas for strengthening training and service delivery systems, particularly through the adaptation of the PEPFAR technical considerations into the national curricula on clinical management of survivors of sexual violence in Kenya, with job aids and checklists to help in service delivery with a focus on child and adolescent survivors of sexual violence. It is anticipated that training curricula will inculcate methodologies that enhance provider performance through skills building and on-the-job assessment to ascertain translation of knowledge gained through the training into practice, in addition to facilitating the provision of holistic care by defining the comprehensive care package required by child and adolescent survivors of sexual violence. Findings of this review also flag the importance of job aids as quick reference materials for providers in their daily routine at various facilities. The review findings consequently provided a platform to IntraHealth to facilitate inclusion of a module on management of child and adolescent survivors in the national training curricula on sexual violence. Included in the training curricula are job aids and provider pre- and post-training competency assessment tools. The training methodology has also been reviewed to facilitate delivery of skills-based training of providers.

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APPENDIX 3. TRAINING NEEDS ASSESSMENT REPORT

Rollout of the PEPFAR Technical Considerations for the Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence

Part II: Assessment of the Readiness of Health Facilities and Providers to Respond to the Needs of Child and Adolescent Survivors of Sexual Violence

May 2015

FUNZOKenya Project and
Capacity*Plus*, IntraHealth International

ACKNOWLEDGEMENTS

The assessment on "The Readiness of Health Facilities and Providers to Respond to the Needs of Child and Adolescent Survivors of Sexual Violence" was the result of a collaborative effort between the Ministry of Health in six counties (Tharaka-Nithi, Embu, Meru, Kitui, Machakos, and Makueni), IntraHealth International through FUNZOKenya and global Capacity*Plus* projects, and APHIA*Plus* Kamili. We thank the medical superintendents and health facility managers from the 18 facilities targeted by this assessment and the health workers who were the respondents.

We recognize FUNZOKenya project staff for providing overall implementation leadership for the assessment, especially Peter Milo and Peter Shikuku. Judith Karia, Ian Wanyoike, and Janet Makena provided leadership for data collection and interfaced with the leadership in the assessment counties. Additionally, we recognize Stella Gitia and Dorothy Mwatha from the APHIA*Plus* Kamili zone for the follow-up with health facility in-charges in the six counties in the upper and lower Eastern regions that were targeted by this assessment. Constance Newman, Dr. Alfredo Fort, and Alex Collins from Capacity*Plus* provided overall technical assistance to the USAID/Office of HIV/AIDS-supported gender-based activity in Kenya and, more specifically, for adapting the draft assessment tool to the Kenyan context and supporting data analysis.

Carolyne Ajema, a consultant on sexual and gender-based violence (SGBV), was invaluable in providing technical expertise in the interpretation of the assessment findings as they relate to the SGBV environment in Kenya and, specifically, to children and adolescents who have experienced SGBV.

IntraHealth International in Kenya looks forward to more collaborative assessments with the Ministry of Health's Reproductive and Maternal Health Service Unit (RMHSU), which will lead to improvements in service delivery by addressing factors that promote or hinder application of training for performance at the workplace by service providers.

Thanks.

Dr. James Mwanzia
Chief of Party
IntraHealth International, FUNZOKenya Project

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Acronyms

ARV	Antiretroviral
EC	Emergency contraception
GBV	Gender-based violence
HVS	High vaginal swab
OPD	Outpatient department
P3	Kenya Police Medical Examination Form
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PRC	Post-rape care
SGBV	Sexual and gender-based violence
SOP	Standard operating procedure
STI	Sexually transmitted infection
WHO	World Health Organization

EXECUTIVE SUMMARY

Violence against children and adolescents is a global public health concern. The World Health Organization estimates that 150 million girls and 73 million boys experience sexual abuse before reaching 15 years of age. In Kenya, it is estimated that one in three females and one in five males experience at least one episode of sexual violence before reaching age 18. This exposure to sexual violence has been found to influence the adoption of risky behaviors by children when they become adolescents.

Sexual and gender-based violence (SGBV) results in diverse health, social, and mental consequences, giving rise to the need for comprehensive services by all survivors. Health care constitutes an essential component of the necessary interventions to mitigate the consequences of child sexual violence. The government of Kenya through the Ministry of Health has developed national guidelines on management of survivors of sexual violence and a clinical training manual for health providers. However, no evidence exists on the extent to which health facilities are resourced with personnel, equipment, commodities, and service protocols to deliver child and adolescent friendly services to survivors.

The USAID-funded Capacity*Plus* and FUNZOKenya projects, led by IntraHealth International, were asked to implement an intervention to assess the feasibility of incorporating PEPFAR's publication "The Clinical Management of Children and Adolescents who have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs" into current materials, and its effect on the knowledge, skills, and practices of trainers and providers. Before application of the intervention, we carried out a training needs assessment in 18 public health facilities. The focus was to assess service providers' perceptions and capacity in providing SGBV services to children and adolescents, and assess capacity of health facilities in providing SGBV services according to set standards.

The assessment, conducted in February 2015, used a cross-sectional study design and purposively sampled 18 health facilities and 35 providers who had previously been trained on SGBV management with the FUNZOKenya project. Ultimately, 30 providers were interviewed using a structured tool. SPSS was used to analyze data across eight themes: leadership and supervision; provider perceptions of sexual and reproductive health; provider knowledge, skills, and experience; health facility infrastructure; equipment, supplies, and storage; standards and policy guidelines in place at the facility level; and referral systems and multisectoral linkages.

Nearly half (n=13) of the providers interviewed were nurses, and 43% had worked less than five years in reproductive health or had undergone reproductive health-related trainings. Over 70% of the providers had attended child or adolescent survivors of sexual violence. More than half (n=19) of the providers had been trained specifically on clinical management of sexual violence survivors, but five of these had not attended any survivors post-training due to transfers to other departments that do not directly deal with survivors. The majority of the providers were able to offer the minimum health care package to survivors. However, 52% and 38% of providers

were not familiar with the male and female genital/anal examination protocols, respectively. Two-fifths (40%) of respondents indicated that their facilities had the equipment and supplies necessary for the provision of post-rape care services. However, some of the equipment was not available to survivors who presented at night, when laboratory services are not offered. Most (70%) providers had not received supervision on their performance at the facility in the six months prior to the assessment. Half (53%) of the providers indicated the lack of a county-level SGBV focal person responsible for coordination and provision of oversight into reproductive health matters with a specific focus on SGBV, as outlined in the training curriculum on clinical management of survivors that is under review. No feedback mechanisms exist on how providers can enhance their skills in managing child and adolescent survivors. Providers who received supervision had seen more cases of child/adolescent sexual violence than their counterparts who did not receive any supervision. Referral of survivors was not standardized despite some facilities having their own customized forms.

While national guidelines on management of sexual violence in Kenya outline the minimum package of care to be provided to survivors, they do not provide clear guidance for the management of child and adolescent survivors. There is need for adaptation of the PEPFAR-developed Technical Considerations for the Clinical Management of Children and Adolescents who have Experienced Sexual Violence into the national guidelines. The providers' training manual on clinical care for survivors does not provide for skills-based training on management of child and adolescent survivors and needs to be reviewed to adequately provide skills practice on the management of child and adolescent survivors of sexual violence. Facilities also should be equipped with the required equipment and commodities to provide quality services. Modalities should be developed to provide continued supervision of providers engaged in management of child and adolescent survivors—at both the county and facility levels. In addition, there is need for a supervisory structure for reproductive health and SGBV at the county level. Referral pathways for child and adolescent survivors both within and outside the health sector should be developed and disseminated.

INTRODUCTION

Global and Regional Context of Sexual Violence

Globally, gender-based violence (GBV) remains a public health problem (World Health Organization 2005). Sexual violence is the most common form of GBV. The World Health Organization (WHO) defines sexual and gender-based violence (SGBV) as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work." Worldwide, an estimated 1 in 3 women will experience some form of SGBV in their lifetime (Erulkar 2004). A multicountry study conducted by the WHO in ten developing countries found that 15%-71% of women reported experiencing either intimate partner or sexual violence at some point (WHO 2005). A study conducted among high school students in Addis Ababa found that the prevalence of rape and attempted rape was 5% and 10%, respectively (Mulugeta, Kassaye, and Berhane 1998).

Child sexual abuse is also a critical public health, human rights, and developmental issue that has severe consequences affecting both the immediate and long-term health and well-being of children. Guidelines for the clinical management of child sexual abuse define it as "an activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust, or power, the activity being intended to gratify or satisfy the needs of the other person" (ECSA-HC 2011). The WHO estimates that 150 million girls and 73 million boys experience sexual abuse before age 15 (Krug et al. 2002). A study found that more than one-fourth (29.4%) of adolescents aged 15-19 had experienced intimate partner violence (WHO 2013). Meta-analyses indicate that nearly a quarter of adults (22.6%) worldwide suffered physical abuse as a child, over one-third (36.3%) experienced emotional abuse, and 16.3% experienced physical neglect (Stoltenborgh et al. 2012; Stoltenborgh et al. 2013). Lifetime child sexual abuse for girls and boys stands at 18% and 7.6%, respectively (Stoltenborgh et al. 2011).

The occurrence of SGBV is rooted in unequal gender dynamics and social and cultural norms (Tarayia 2004). In sub-Saharan Africa, sexual violence is largely linked to societies organized along patriarchal lines. Patterns of male domination, male entitlement, and female submission often lead to increased vulnerability for women and girls with respect to sexual violence (Stoltenborgh et al. 2013). A wide range of health consequences is associated with sexual violence, including physical injuries, reproductive health problems, psychological trauma, emotional distress, and sociobehavioral consequences (Jewkes, Sen, and Garcia-Moreno 2002). These introduce the need for comprehensive health-related response strategies. In addition, health providers need to develop improved skills to facilitate better delivery of care to child and adolescent survivors of sexual violence using existing national guidelines and standards.

Child and Adolescent Sexual Violence In Kenya

Sexual violence in Kenya is common (Waki Commission 2008). The Kenya Demographic and Health Survey of 2014 indicates that almost two-fifths (38%) of Kenyan women aged 15–49 have experienced physical or sexual violence, including "forced sexual initiation." Approximately 11% of adolescent girls aged 15-19 years reported SGBV in one study (National Council for

Population and Development 2012). The high rates of sexual violence experienced by girls and young women contribute to an increased risk of unwanted pregnancy when compared to adult women, due to the barriers that young women face in accessing contraception and sexual and reproductive health information. Many girls aged 15 to 19 years give birth each year, accounting for approximately 11% of all births worldwide. In Kenya, as elsewhere, many of the pregnancies among young persons are linked to sexual violence. Experiences of young men who have been raped and accessed health services have not been documented in Kenya.

Although women and girls are the most affected by sexual violence, men and boys also suffer from its consequences (Ajayi et al. 1997). The Violence against Children (VAC) Survey carried out in Kenya indicates that child sexual violence is widespread for both sexes (Government of Kenya and Ministry of Gender, Children and Social Services 2012). At least 32% of females and 18% of males reported experiencing sexual violence during their childhood (Government of Kenya and Ministry of Gender, Children and Social Services 2012). Another study carried out among 1,753 adolescents in Kenya revealed that 11% of males and 21% of females had been sexually coerced (Erulkar 2004).

Other sources of data on sexual violence include police reports. A 2011 police crime report documented 2,660 cases of defilement, defined by the Kenya Sexual Offences Act as "carnal knowledge with an individual who is below 18 years of age." Available police data primarily classify these cases by type of sexual offence but not by gender, making it difficult to determine how many were reported by males versus females. Police numbers underreport defilement in comparison with media reports on cases of defilement.

Despite the widespread occurrence of sexual violence in Kenya, anecdotal evidence suggests that many cases go unreported due to fear, stigma, and lack of support to survivors by their families or society at large. In the VAC study mentioned above (Government of Kenya and Ministry of Gender, Children and Social Services 2012), less than 10% of females and males who experienced sexual, physical, or emotional violence as a child received professional care. In addition, little documentation is available to establish the extent to which existing services in Kenya are responsive to the needs of children and adolescents who report to health facilities after being defiled.

Current Sexual Violence Response Mechanisms in Kenya

Sexual violence results in diverse consequences, necessitating a comprehensive and responsive management approach. In Kenya, progress has been made toward strengthening responsiveness to survivors' needs. Efforts include systems strengthening (through infrastructure development and commodity supply), capacity building, and policy formulation. Policies and standards in place to improve the response to sexual violence in Kenya are highlighted below.

Health sector

National policy guidelines. The Ministry of Health has put in place national guidelines on the management of sexual violence (Ministry of Health/Division of Reproductive Health 2009). According to these guidelines, core components of a comprehensive response to sexual violence and exploitation include clinical evaluation, examination, and documentation; HIV

testing and HIV prevention through the use of post-exposure prophylaxis (PEP); pregnancy prevention through the provision of emergency contraception (EC); sexually transmitted infection (STI) management; counseling for trauma; and referral for the ongoing well-being of survivors (Ministry of Health 2013, 2014). This is in line with what is stipulated in various regional and international guidelines and curricula on management of survivors of sexual violence (Krug et al. 2002; UNFPA Asia-Pacific Office 2010; WHO 2003, 2005). However, the guidelines do not have clear provisions on how to sensitively and considerately deliver the components of care to child and adolescent survivors of sexual violence, nor is the extent to which providers adapt these standards to respond to the unique needs of child and adolescent survivors of sexual violence well documented. Table 1 outlines the minimum package of post-rape care (PRC) for survivors of sexual violence, irrespective of gender or age group.

Table 1: Minimum Standards for Providing Comprehensive Post-Rape Care in Health Facilities*

Facility capacity/level	**Minimum standards for medical management**	**Reporting/recording requirements for health facilities**	**Minimum capacity requirements at health facilities**
All health facilities without a laboratory (public and private)	ÅManage injuries as much as possible ÅObtain detailed history, examination, and documentation (refer for high vaginal swab [HVS], PEP/EC, STI)	ÅFill in PRC form in triplicate ÅMaintain PRC register ÅEnsure survivor gets a copy of the PRC form and takes it to the laboratory	ÅA trained nurse
All health facilities with a functioning laboratory (public and private)	ÅObtain detailed history, examination, and documentation (including HVS) ÅIdeally, provide first doses of PEP/EC (even where follow-up management is not possible) ÅWhere HIV testing and counseling services are available, provide initial counseling	ÅFill in PRC form in triplicate ÅMaintain PRC register ÅMaintain a laboratory register ÅRefer to a facility offering comprehensive PRC services	ÅA trained nurse and/or clinical officer ÅA trained counselor (where counseling is offered)
All health facilities with antiretrovirals (ARVs) or a comprehensive care clinic where adherence to ARVs can be monitored and comprehensive PRC services can be provided (private and public)	ÅManage injuries as much as possible ÅObtain detailed history, examination, and documentation ÅProvide emergency and ongoing management of PEP ÅProvide EC ÅProvide STI prophylaxis or management ÅProvide counseling for trauma, HIV testing, and PEP adherence	ÅFill in PRC form in triplicate ÅMaintain PRC register ÅMaintain a laboratory register ÅFill in PRC form to follow up management of survivors	Å1 medical officer or clinical officer trained in ARV/PEP management Å1 trained counselor (trauma, HIV testing, PEP adherence counseling) ÅLaboratory for HIV and HB testing ÅPreservation of sperm from HVS specimen

*Table adapted from the 2014 national guidelines on management of sexual violence in Kenya

Training curricula. Curricula developed by the Ministry of Health include a national trauma counselors training manual and a national curriculum on clinical management of survivors of sexual violence (Ministry of Health 2006a, 2006b). These provide a benchmark for how providers are expected to provide clinical and psychosocial support to survivors. However, the two curricula lack explicit sections on management of child and adolescent survivors. Moreover, the training methodology is mostly didactic, places greater emphasis on theory than on skills development, and focuses more on adult survivors of sexual violence. Providers, therefore, are not well equipped to translate knowledge gained into an understanding of how to manage child and adolescent survivors. In addition, these curricula do not provide mechanisms for evaluating the extent to which the training curricula actually enhance providers' performance in the management of child and adolescent survivors of sexual violence. Finally, the two curricula do not conform to the provisions contained in the national guidelines of 2014 on the management of sexual violence survivors.

Standard operating procedures. Kenya's national Health Sector Standard Operating Procedures (SOPs) for Management of Sexual and Gender-Based Violence are aimed at guiding facility-level service providers in the public and private sectors on the provision of comprehensive medico-legal care, linkages, and psychosocial support to survivors of sexual violence (Ministry of Health 2013). However, there is a lack of documented evidence on the extent to which health providers adhere to these standards and how these standards can be adapted to the management of child and adolescent survivors. There are no SOPs explicitly for the clinical management of child and adolescent survivors of sexual violence. The existing SOPs are yet to be disseminated by the Ministry of Health to all health facilities.

Legal sector

In addition to health sector policies, the government of Kenya has developed a number of legislative frameworks. However, the extent to which health providers are informed about these policies is not well documented. Legal frameworks include:

- The Sexual Offences Act, which provides for the definition, prevention, and protection of all persons from unlawful sexual acts
- The 2001 Children's Act, which provides for the rights, protection, and care of children
- The Witness Protection Act of 2006, which provides for the protection of witnesses in criminal proceedings
- The Criminal Procedure Code
- The Evidence Act
- The Bill of Rights as enshrined in Chapter Four of the 2010 Constitution.

PROBLEM STATEMENT

The medical treatment regulations for Kenya's Sexual Offences Act require all doctors, nurses, and clinical officers to be able to offer the post-rape package of care to survivors of sexual violence in health facilities. Kenya has developed policies to clearly outline this package of care. As already noted, however, the national guidelines fail to stipulate how to make services

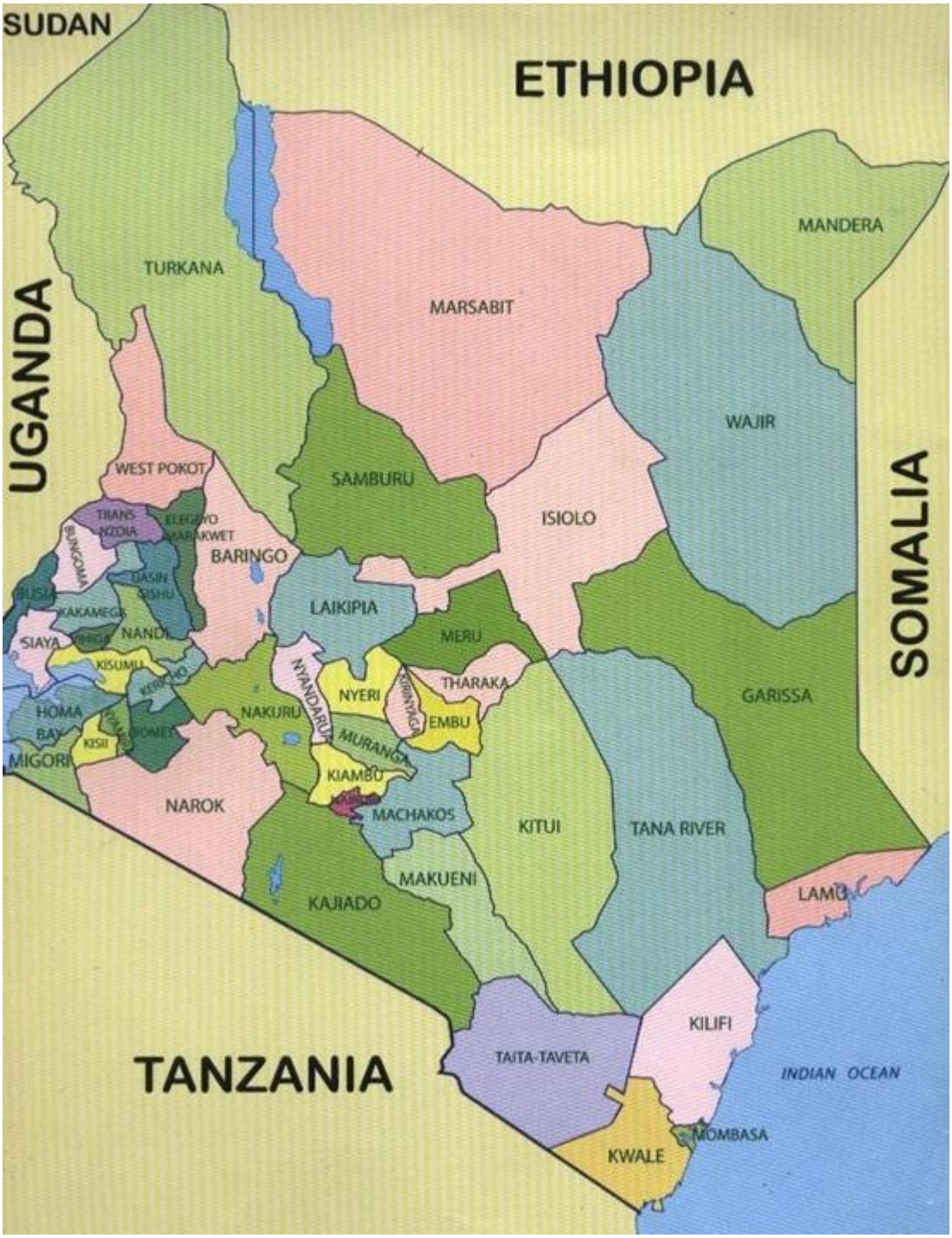
responsive to the specific needs of child and adolescent survivors. In addition, it is not clear to what extent health workers are equipped with appropriate skills to provide standardized, quality, and comprehensive services to child and adolescent survivors of sexual violence. Not all health providers have undergone the Ministry of Health training on clinical management of survivors of sexual violence, and it is unclear whether providers who have undergone this training feel competent to manage child and adolescent survivors.

An opportunity arose to bridge some of these gaps through the USAID-funded and IntraHealth International-led Capacity*Plus* and FUNZOKenya projects. The two projects leveraged funding from USAID's Office of HIV/AIDS (OHA) to incorporate the content of AIDSTAR II's publication, "The Clinical Management of Children and Adolescents who have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs," into current national training materials on sexual violence and to assess its effects on the trainers' and providers' knowledge, skills, and practices. This training needs assessment (TNA) sought to establish baseline information on the extent to which providers who had already undergone training on clinical management of survivors of sexual violence consider themselves competent to attend to child and adolescent survivors. The assessment also assessed the capacity of the facilities where these trained providers work to provide services according to established standards and SOPs on management of sexual violence in Kenya.

Purpose of Study

The TNA assessed the readiness of the health system (facilities and providers) to respond to child and adolescent survivors of sexual violence in 18 health facilities in Kenya's Lower and Upper Eastern regions. The Upper Eastern region counties consist of Embu, Meru, and Tharaka-Nithi, while the Lower Eastern region comprises the counties of Kitui, Machakos, and Makueni (see Figure 1).

Figure 1. Counties in Kenya, including Intervention Counties



Goals and Objectives

The TNA had three goals:

1. Analyze the perceptions of health providers regarding their role and their readiness to deliver services responding to child and adolescent survivors of sexual violence
2. Assess the knowledge, attitudes, and practices of health providers on management of child and adolescent sexual violence
3. Assess the capacity of health facilities in providing SGBV services according to set standards.

The study's specific objectives were to assess:

- Health care providers' perceptions of SGBV issues
- Health care providers' skills, knowledge, and experience
- Leadership and supervision mechanisms and structures at health service delivery sites
- Adequacy of health service infrastructure for the provision of SGBV services to child and adolescent survivors of sexual violence at health service delivery sites
- Adequacy and availability of equipment, supplies, and storage at health service delivery sites
- Adherence to national protocols and guidelines on management of sexual violence
- Referral systems for sexual violence and multisectoral linkages at health service delivery sites.

Methodology

Study Design

The assessment employed a cross-sectional descriptive design that incorporated a mix of qualitative and quantitative methods.

Sampling

Two units of analysis were used: (1) Health facilities involved in the delivery of post-rape care services, and (2) health providers in those health facilities who had been trained in 2012 by APHIA*Plus* Kamili and Liverpool VCT, Care and Treatment (LVCT)—now known as LVCT Health—on the clinical management of sexual violence with support from the USAID-funded FUNZOKenya project. Both the health facilities and respondents were purposively selected bearing in mind the objectives of the assessment.

Health facilities

In all, 18 public health facilities were sampled purposively, with a focus on facilities where the providers targeted for the assessment worked. These facilities, located in six counties in the Lower and Upper Eastern regions (Figure 1), currently fall under the APHIA*Plus* Kamili project

zones. The ten facilities in the Lower Eastern region and the eight facilities in the Upper Eastern region were distributed across the six counties as follows:

- Lower Eastern region: Machakos county (5 facilities), Kitui (2 facilities), and Makueni (3 facilities)
- Upper Eastern region: Tharaka-Nithi county (2 facilities), Meru (4 facilities), and Embu (2 facilities).

The FUNZOKenya project sent requests to engage with health care providers from these facilities prior to the commencement of the assessment. Letters were sent to the county Executive Ministers of Health for authorization. The assessment team also made a courtesy call to the health facility administration before reaching out to the sampled providers.

Health care providers

Health care providers were eligible for this study if they had undergone a SGBV training supported by FUNZOKenya in 2012 in liaison with LVCT Health on the management of survivors of sexual violence. Only health providers who had undergone the SGBV training and were involved in management of survivors were selected for the assessment. Previously trained providers who had relocated to other service delivery points not involving survivors of sexual violence were not sampled; instead, the providers who replaced them were sampled. A sample of 35 health providers was selected, but only 30 providers (21 women and 9 men) were actually interviewed because the remaining five had relocated to other health facilities or to duty stations not involved in post-rape care within the sampled health facilities.

Data Collection

The assessment tool, a semi-structured interview guide (see Annex 1), was developed by Capacity*Plus* and FUNZOKenya and reviewed by program teams from FUNZOKenya and the APHIA*Plus* Kamili project before being finalized for data collection. The review session was facilitated by IntraHealth's assistant director for regional strategy, a curriculum development manager, and a SGBV consultant. The review focused on facility entry processes, use of the study tools to conduct interviews, variables addressed under the different themes, and selection of respondents. Data collection took place from February 24-27, 2015.

A five-person team of three women and two men from FUNZOKenya and APHIA*Plus* Kamili collected data at the 18 sites after undergoing a one-day training on use of the assessment tool. The semi-structured interview guide collected data on eight thematic areas:

1. Health care provider background information
2. Leadership and supervision
3. Provider perceptions, knowledge, and experience on management of sexual and reproductive health and sexual violence
4. Provider knowledge, self-reported skills, and experience on sexual violence management
5. Health facility infrastructure
6. Equipment, supplies, and storage

7. Availability of national standards and policies at the facility level
8. Referral systems and multisectoral linkages in place.

Data Analysis

Capacity*Plus* monitoring and evaluation staff entered the data. Analysis of the quantitative data was done using SPSS to generate frequency distributions and cross-tabulations. The qualitative data were entered in Microsoft Word and analyzed using content analysis techniques.

Limitations

The team encountered and addressed several limitations during the assessment, including issues of staff mobility, nonresponse or missing information, and the small sample size.

Staff mobility and practice

Some of the health care providers trained in 2012 had been transferred to other departments and were currently not providing health care services related to sexual violence. These providers were interviewed nevertheless, but some had never practiced SGBV care since receiving the training, meaning that their responses were not as practice-based as those of other providers actively caring for child and adolescent sexual violence survivors. The limitations of the data provided by non-practicing providers was taken into account during data analysis.

Non-response

All responses were voluntary. Because of the sensitive nature of the topic, some questions were met with non-response.

Sample size

The small size of the health provider sample (in addition to purposive sampling) precludes comparisons based on statistical significance and makes it impossible to generalize the results to the entire country. However, the study's results are internally valid for the purpose of testing the usefulness of the new child and adolescent training content for these providers.

RESULTS

Providers' Sociodemographic Characteristics

Region, county, and facility

The 30 providers were drawn from county referral hospitals, county hospitals, subcounty hospitals, and health centers (Table 2). Providers ranged in age from 28 to 57 years, and 70% were female. Their mean age was 44 years.

Table 2: Respondents by Facility Type

Region	Level of Facility				
	Health centers	Subcounty hospitals	County hospitals	County referral hospitals	Total
Lower Eastern	1	5	2	1	9
Upper Eastern	2	6	11	2	21
Total	**3**	**11**	**13**	**3**	**30**

*Two respondents did not provide these details.

As shown in Table 3, providers stationed in health centers and subcounty hospitals were younger than their county and county referral hospital counterparts (p=0.01).

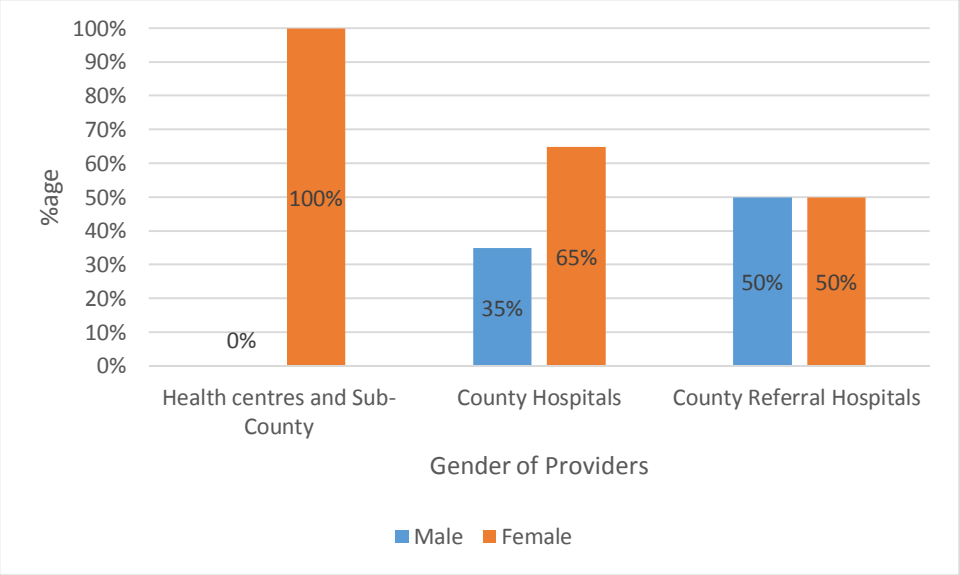
Table 3: Providers by Age

Level of Facility	Mean Age (n)
Health center and subcounty hospital	33.8 (4)
County hospital	44.3 (20)
County referral hospital	48. (4)
Total	**28**

p=0.01

When analyzed by type of facility, all of the providers in the health centers and subcounty hospitals were female, whereas the gender distribution was 50:50 at the county referral hospital level. Though the small sample size precludes assessing the statistical significance of these differences, the numbers seem to indicate a trend toward a relatively higher presence of male staff at higher-level health facilities (see Figure 2).

Figure 2: Providers by Gender and Facility Type



Designation of providers

Half of the providers interviewed were nurses (50%) (see Table 4). Another fourth (27%) were heads of departments, while the remaining respondents were clinical officers (10%), county coordinators (10%), and laboratory personnel (3%). The providers were stationed at a variety of posts, including outpatient departments, comprehensive care clinics, eye clinics, laboratories, county offices, wards, youth-friendly centers, medical training institutions, mental health clinics, and at facility administration.

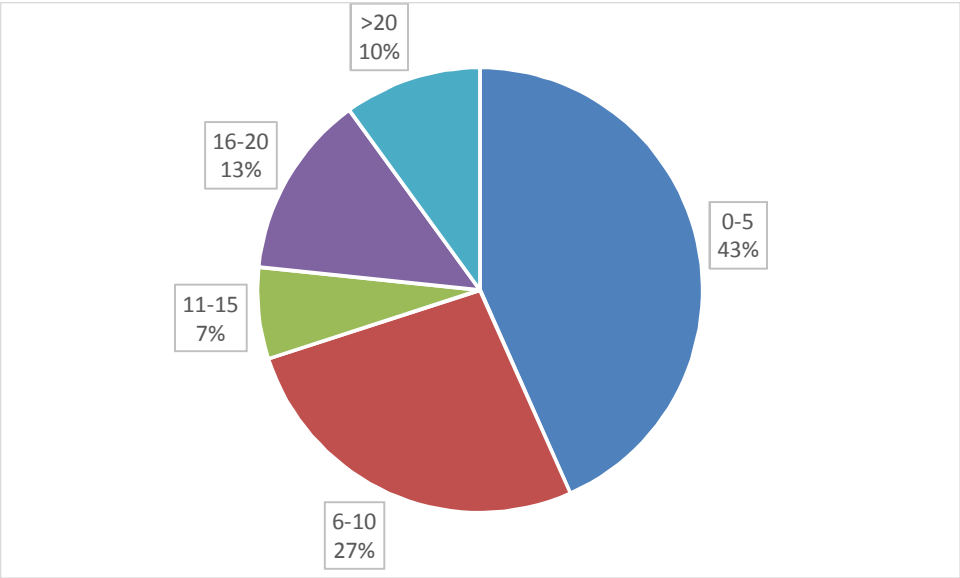
Table 4: Cadres of Providers Interviewed

Region	Clinical Officer	Nursing Officer	Public Health Officer	Head of Department	County Coordinator	Senior Medical Laboratory Technologist	Total
Lower Eastern	2	5	1	6	3	0	**17**
Upper Eastern	1	8	0	2	1	1	**13**
Total	**3**	**13**	**1**	**8**	**4**	**1**	**30**

Years of reproductive health work experience

Over two-fifths (43%) of the providers had worked in reproductive health for less than five years (see Figure 3). However, 30% had at least a decade of reproductive health experience.

Figure 3: Number of Years Worked in Reproductive Health



Trainings attended by providers

Further analysis was undertaken to determine how many reproductive health-related trainings the providers had attended in the last three years. For the purpose of this assessment, reproductive health trainings included any training on family planning, maternal and neonatal health, postnatal care, or STI management. Approximately half (47%) of the providers had not undergone any reproductive health training. The majority (87%) of providers had attended at least one training on gender, violence against women, and/or human rights, but some respondents did not indicate who offered this training.

By region (see Figure 4), more than half of providers (53%) in the Lower Eastern region had not undergone training in reproductive health. However, slightly more providers from this region had been trained on GBV and sexual violence than in the Upper Eastern region. It was not possible to tell from the responses which institution(s) had offered the training on GBV and sexual violence.

About three-fourths (77% or n=23) of the providers had undergone one additional training on sexual violence over the last three years. Nearly all (22/23) of these providers had been trained on clinical care of survivors, 19 by the FUNZOKenya project and three by LVCT Health. Five of the providers trained did not attend any child and/or adolescent survivors of sexual violence following the training.

Figure 4: Number and Type of Trainings Attended, by Region

RH: reproductive health; VAW: violence against women; SV: sexual violence

Leadership and Supervision

This thematic area sought to gather information about the sensitization of members of facility health management teams on SGBV; the presence of designated subcounty or county SGBV health management focal persons; the presence of SGBV supervisors in facilities; and the level or frequency of provider supervision at the facility level.

According to 25 respondents, efforts had been put in place to facilitate sensitization of health management teams on SGBV issues. More than 80% of providers reported that members of their facility's health management team had been sensitized, but half (53%) also indicated there was no designated county focal person to provide leadership on SGBV management (Figure 5).

Two-thirds (67%) of the health providers affirmed the existence of a supervisor in charge of SGBV matters in the hospitals. Despite this, only 30% of the providers reported having been supervised at the facility level over the last six months (Figure 6). This assessment did not target SGBV supervisors to obtain more information on their role in the facility vis-à-vis frequency or content of their supervision.

Figure 5: County-Level SGBV Health Management Focal Person

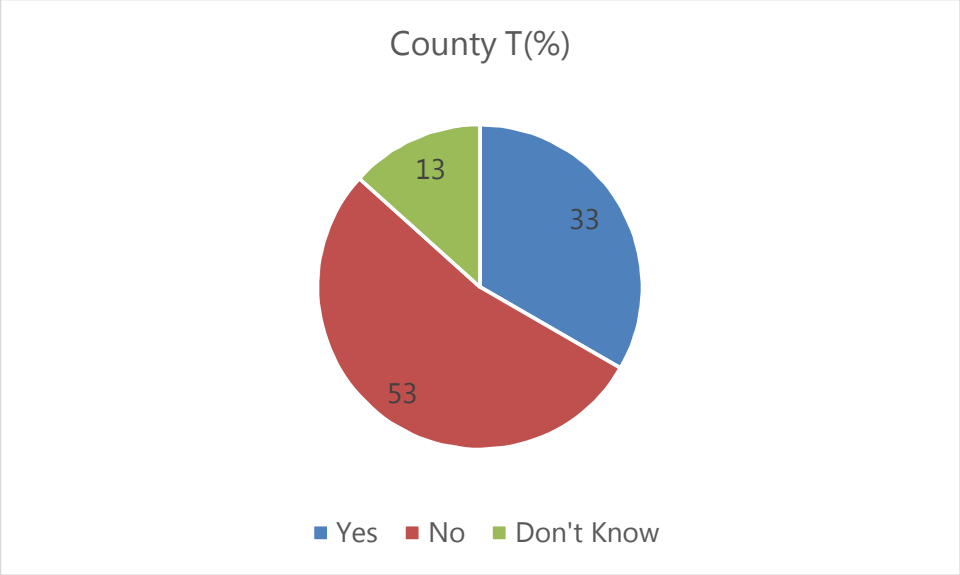
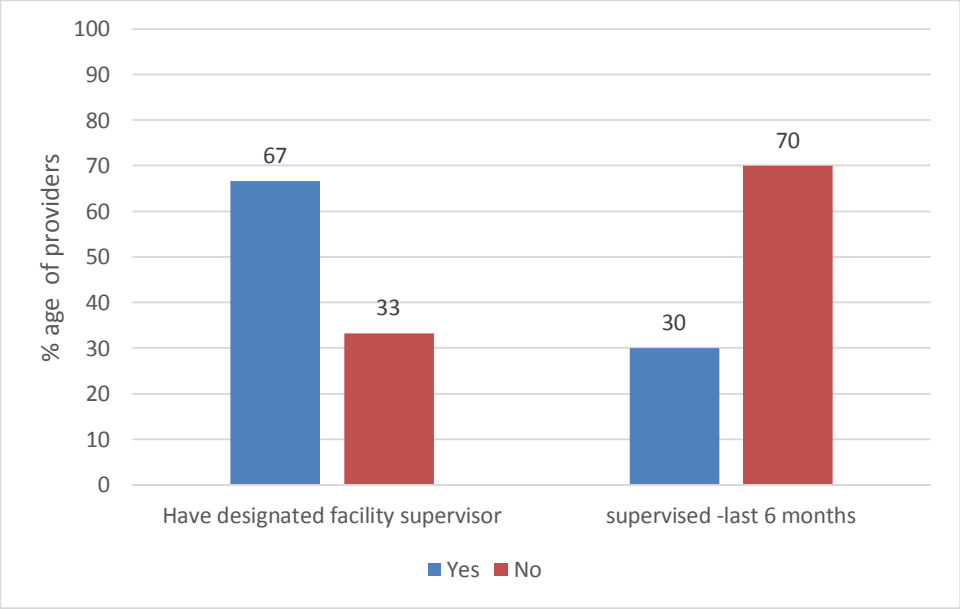


Figure 6: Facility-Level SGBV Supervision



Four providers described problems with structured supervision in their facilities. As one provider stated, "Although there is a designated focal person on SGBV, there is no regular supervision." As a result, some providers have opted for peer-to-peer mentorship. Six providers indicated that their supervisors had either taken up new assignments within the health facility or had been transferred to other facilities or Ministry of Health departments. Another provider observed, "At one time, there was a nurse coordinator based in the OPD [outpatient department] to supervise GBV issues and counseling, but [she] was rotated to a different department."

Only 20% (n=6) of providers indicated that their supervisor had reviewed their performance in relation to how they handled cases of SGBV, in addition to providing feedback on their management of SGBV cases presenting at the facility.

Further analysis was undertaken to identify differences in supervision across the health facilities. Table 5 shows that there was no statistical difference, but there is a trend indicating that relatively more supervision seems to be done at the primary health care levels.

Table 5: Supervision, by Level of Facility

In the last 6 months, have you been supervised by your supervisor?	Subcounty hospitals and health centers	County hospitals	County referral hospitals
Yes	2 .0	6 .0	0 .0
No	2 .0	14 .0	4 .0
Total	**4 .0**	**20 .0**	**4 .0**

Provider Perceptions of Service Delivery

We assessed provider perceptions and feelings toward different aspects of gender, GBV, and their readiness to deliver services. We also sought to explore provider perceptions of factors that contribute to the occurrence of SGBV in communities, such as poverty, corrupt leaders, lack of access to health, and gender inequality. For each question, we asked the providers to tell us to what extent they agreed or disagreed with the answers we suggested. Response options ranged from "strongly agree," "partially agree," "neither," "partially disagree," to "strongly disagree."

Provision of reproductive health services to children and adolescents

Table 6 outlines provider attitudes toward adolescents seeking contraceptives.

Table 6: Provider Attitudes about Adolescent Access to Contraceptives, by Provider's Sex

		Male (n=9)	**Female** (n=20)	**Total**
Adolescents are too young to be asking for the use of contraceptives	Strongly agree	22.2%	0.0%	6.9%
	Partially agree	11.1%	10.0%	10.3%
	Partially disagree	22.2%	10.0%	13.8%
	Strongly disagree	44.4%	80.0%	69.0%
Total		**100.0%**	**100.0%**	**100.0%**

Although the numbers are too small to confirm statistically, generally there seems to be more

agreement among male providers (33%) about adolescents being too young to ask for use of contraception than among female providers (17%).

Further analysis revealed that 97% of the providers did not agree with the statement that "A child who reports being sexually abused may be telling lies or fantasies so it's OK to not believing in them at first." In a test of contrasting statements, 93% agreed wrongly that in the case of child or adolescent survivors of sexual violence, all efforts should be made to conduct a medical forensic exam to reveal the truth, while the same proportion disagreed with the statement that a medical exam should only be undertaken if the child is willing or if it is necessary for medical treatment. The opposite response (agreement) should have been selected because, according to the *Technical Considerations* document (page 8), "Children should NEVER be forced to undergo the medical forensic examination against their will unless the examination is necessary for medical treatment."

On whether reporting to police should be a prerequisite to medical care, 77% of providers rightly disagreed, and relatively more male (89%) than female providers (71%) agreed that it should not be a prerequisite.

Occurrence of child and adolescent sexual violence and contributing factors

We sought to explore perceptions regarding socioeconomic factors documented in the literature that may increase vulnerability to sexual abuse, including poverty, corruption among leaders, lack of access to health, and gender inequality. Table 7 highlights providers' perceptions of these factors. Using a 1-10 scale, providers from the Lower Eastern region reported perceiving a higher prevalence of poverty (8.0) than their Upper Eastern counterparts (6.0), with a p value of .005. Other negative conditions were perceived as less critical, and there were no differences in perceptions between the two regions.

Table 7: Socioeconomic Contributors to Sexual Violence (1-10 Scale)

Region		Poverty	Corrupt leaders	Lack of access to health for women and children	Gender inequality
Lower Eastern	Mean	8.00	5.13	4.41	4.47
	N	17	16	17	17
Upper Eastern	Mean	6.00	5.92	4.62	5.85
	N	13	13	13	13
Total	Mean	7.13	5.48	4.50	5.07
	N	30	29	30	30

In addition, providers from county hospitals reported corrupt leaders (6.2) and violence against women (6.8) slightly more than their counterparts at subcounty hospitals and health centers (4.8 for both) and county referral hospitals (3.3 and 3.8, respectively), although the small sample makes it impossible to confirm these differences statistically (p values of 0.36 and 0.09, respectively).

Occurrence of child and adolescent sexual violence

The assessment also sought to establish providers' opinions about the frequency of occurrence of sexual abuse in adolescents and children (Table 8). On a scale from 1 to 10, male providers reported perceiving a lower prevalence of sexual violence and abuse against children (3.3) than their female counterparts (5.8) ($p = .019$).

Table 8: Perceived Occurrence of Child and Adolescent Sexual Violence

Gender		**Sexual violence/abuse against children**	**Sexual violence/abuse against adolescents**
Male	Mean	3.33	4.44
	N	9	9
Female	Mean	5.76	4.90
	N	21	21
Total	**Mean**	**5.03**	**4.77**
	N	**30**	**30**

Knowledge, Skills, and Experience in Managing Child and Adolescent Survivors

Questions assessed providers' knowledge of services to be offered to child and adolescent survivors of sexual violence. Providers were asked about the number of sexual violence cases they had attended to, how comfortable they were in handling cases of child and/or adolescent sexual violence, procedures involved in management of child/adolescent survivors, and their familiarity with various examination and assessment processes.

Number of child and adolescent cases attended

Providers were asked to indicate if they had, since receiving training on the clinical management of survivors, attended child and/or adolescent survivors of sexual violence. A total of 37 child or adolescent survivors had been directly attended by the respondents across the 18 facilities (Table 9).

Table 9: Experience Attending to Child Survivors, by Region

In the last two years, have you ever attended/treated any child who had undergone sexual violence?	**Region**		**Total**
	Lower Eastern n (%)	**Upper Eastern n (%)**	
Yes	8 (72.7%)	11 (100.0%)	**19 (86.4%)**
No	3 (27.3%)	0 (0.0%)	**3 (13.6%)**
Total	**11 (100%)**	**11 (100%)**	**22 (100%)**

Over 86% of providers had attended to either child or adolescent survivors in the last two years. Providers in the Upper Eastern region had slightly more experience than providers in the Lower Eastern region in attending child sexual violence cases, though this difference was not statistically significant ($p = 0.057$). All male providers had attended adolescent cases, compared

to only 86% of the female providers (p=0.000).

Providers who had been supervised in the last six months saw more cases of child and adolescent sexual violence than those who were not supervised (Table 10). However, this difference was not statistically significant (p=0.049) and could be attributed to other confounding factors such as exposure to other trainings on GBV or location in a department where these services are provided on a routine basis.

Table 10: Experience Attending to Child/Adolescent Survivors, by Supervision Status

In the last 6 months, have you been supervised by your supervisor?		**If so, how many child (0-9 years) cases?**	**If so, how many adolescent (10-19) cases?**
Yes	Mean	23.0	21.5
	N	5	6
No	Mean	4.5	11.5
	N	13	13
Total	**Mean**	**9.6**	**14.6**
	N	**18**	**19**

Provider confidence in attending to child and adolescent survivors

One-fifth (20%) of providers reported feeling "very comfortable" and 73% "somewhat comfortable" in managing sexual violence cases in children and adolescents, while 7% felt "somewhat uncomfortable." Providers gave a variety of reasons why they might feel uncomfortable in attending to child and adolescent survivors of sexual violence. These included:

- "Having not undergone training on trauma counseling or management of children"
- "Inadequate skill to facilitate forensic examination"
- "Pressure from the community especially in cases where the perpetrator is known"
- "Limited coping skills by providers due to transference or vicarious trauma."

In some instances, service providers had not attended to any sexual violence survivors and as such had not been able to use knowledge and skills gained through training. It is worth mentioning that one provider felt that some of the cases of child sexual abuse presented were not genuine, making the provider feel "awkward" in attending to them. However, four providers mentioned that the trainings received had made them feel comfortable in attending to child survivors. Table 11 summarizes the responses given.

Table 11: Reasons for Level of Comfort in Attending to Child/Adolescent Survivors

Reason for feeling comfortable/uncomfortable	Percent (n=25)
Deals with specimen only	4.0
Hasn't been trained on handling such cases	24.0
Some child sexual violence services not available at night	4.0
Clients withhold information or leave out some details	16.0

Very comfortable as I'm in charge of GBV	28.0
Late reporting of cases compromises their management	8.0
Few clients report child sexual violence cases	16.0
Total	100.0

Further analysis revealed relatively more experience in attending to child and adolescent survivors among clinical maternal/youth providers than among others, though this was not statistically significant (p=0.068). In addition, as shown in Table 12, clinical and nursing officers seem to have had more experience in attending to child survivors of sexual violence than nonclinical personnel such as public health workers, heads, coordinators, and senior lab officers (p=.004).

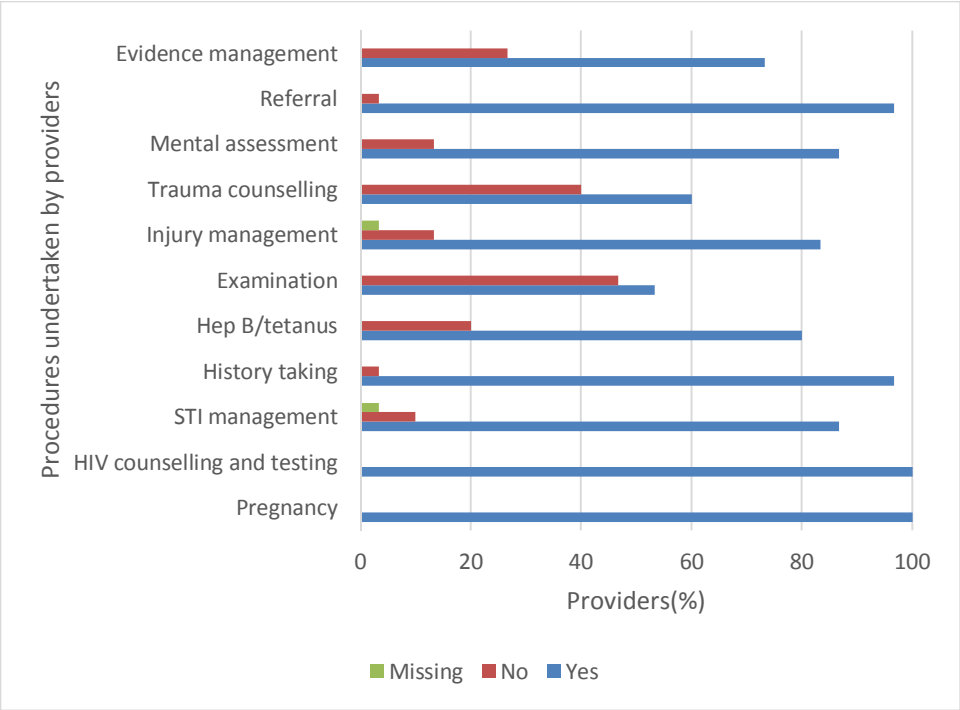
Table 12: Providers' Experience Managing Survivors, by Clinical Designation

In the last two years, have you ever attended/treated any child who had undergone sexual violence?	**Clinical Personnel**	**Nonclinical Personnel**	**Total** (n=22)
	Nursing officers	Public health officers Coordinators Senior lab officers	
Yes	10 (100%)	9 (75.0%)	19 (86.4%)
No	0 (0.0%)	3 (25.0%)	3 (13.6%)
Total	**10 (100.0%)**	**12 (100.0%)**	**22 (100.0%)**

Ability to undertake child abuse clinical management procedures

We sought to establish the extent to which providers considered themselves able to provide prophylactic services, STI management, trauma counseling, forensic examination, history-taking, mental assessment, documentation, and referral in the context of child and adolescent survivors of sexual violence (Figure 7).

Figure 7: Perceived Ability to Clinically Manage Survivors of Sexual Violence

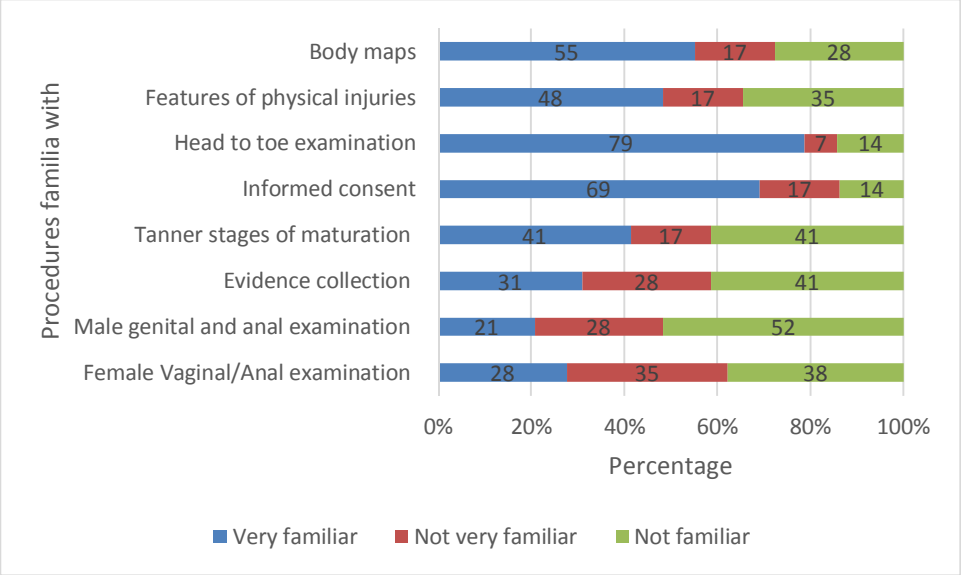


Providers were able to carry out various procedures associated with management of child and adolescent survivors. The vast majority (>80%) had conducted pregnancy testing, administered EC, carried out STI management procedures, offered hepatitis B and tetanus vaccination, evaluated and treated injuries, performed mental or psychological assessments, made referrals to police, and provided psychological support. However, over 43% of the providers affirmed not being able to conduct forensic examination on children and adolescents. This could be attributed to lack of specialized training on forensic examination and evidence collection. One provider indicated that their facility laboratory is not equipped to undertake DNA analysis. In one of the counties, plans are underway to facilitate setting up a forensic laboratory.

Familiarity with clinical management procedures

A 3-point Likert scale was used to determine health providers' level of familiarity with specific procedures of great importance in management of survivors (Figure 8). Providers were generally aware of the different aspects of care, but some lacked the know-how to undertake certain procedures as they were not involved in the direct management of survivors.

Figure 8: Providers' Familiarity with Clinical Management Procedures

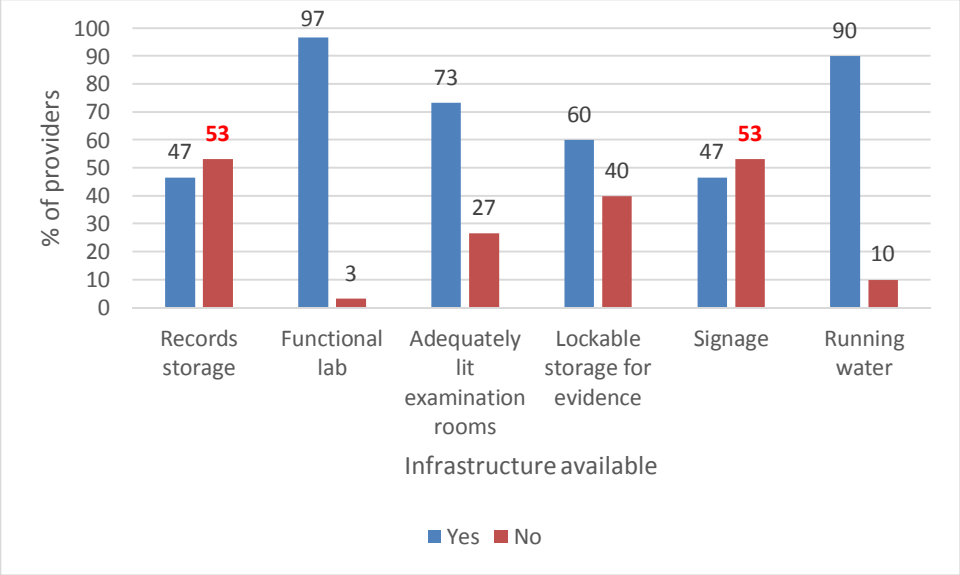


A minority (14%) of the providers were not conversant with how to carry out a head-to-toe examination of child and adolescent survivors. This, according to six providers, was because "Clients undergo most of these processes at the outpatient department." Half of the respondents (52%) lacked skill in examining male survivors, and 41% were not familiar with use of the Tanner stages of maturation to determine prophylaxis to be given to female survivors. Providers also cited the shortage of trained staff as a hindrance to their ability to undertake some of these procedures. However, 69% of providers were conversant with the importance of obtaining informed consent from survivors.

Infrastructure Available for Clinical Management

The assessment asked (and observed when possible) whether health facilities had the required infrastructure to facilitate access to and delivery of services. Over 40% of the health providers indicated their facilities had most of the items required in the delivery of post-rape care services, and over 90% reported running water and a functional laboratory at their facility (Figure 9). However, over 50% stated that their facilities lacked records storage equipment and signage to guide clients on where to receive the different components of the PRC package. Qualitative information confirmed the lack of space to safely store patients' records and evidence.

Figure 9: Infrastructure Available at Health Facilities



Equipment and Supplies for Clinical Management

We assessed the availability of equipment and other necessary supplies required to support delivery of sexual violence management services in each sampled facility (see Table 13).

Table 13: Availability of Equipment and Supplies

Item	Yes N (%)	No N (%)
Examination couch for lithotomy	21 (70%)	9 (30%)
Powder-free nonsterile gloves	22 (73.3%)	8 (26.7%)
Speculum	11 (36.7)	19 (63.3%)
Culture supplies	14 (46.7%)	16 (53.3%)
Prepackaged rape kit	5 (16.7%)	25 (83.3%)
Forensic supplies (bags/tape, urine container, swabs, tape measure)	4 (13.3)	25 (83.3%)
Digital camera	5 (16.7%)	25 (83.3%)
Handheld magnifying glass	2 (6.7%)	28 (93.3%)
Working angle lamp	17 (56.7%)	13 (43.3%)
Sanitary towels	19 (63.3%)	10 (33.3%)
Patient gowns	17 (56.7%)	13 (43.3%)
Pregnancy test	12 (40%)	18 (60%)
Rapid HIV test	30 (100%)	-
PEP	30 (100%)	-
EC	28 (93.3%)	1 (3.3%)
STI drugs	27 (90%)	2 (6.7%)
Needles	30 (100%)	-
Syringes	30 (100%)	-
Vercutainer	29 (96.7%)	1 (3.3%)

Item	Yes N (%)	No N (%)
Antiemetics	26 (86.7%)	3 (10%)
Sharps container	30 (100%)	-
Disposal bin for contaminated wastes	29 (96.7%)	1 (3.3%)

All health facilities involved in the assessment had the essential equipment to offer care to survivors. All respondents indicated that their facilities have sharps containers, HIV test commodities, needles, syringes, and PEP. However, 93% of respondents indicated their facilities did not have a handheld magnifying glass, which is necessary in examination of injuries. Moreover, 83% did not have forensic examination equipment and rape kits despite these items being itemized in the national guidelines on the management of sexual violence as part of the essential equipment health facilities should have in supply. Three-fifths (60%) of respondents indicated a lack of pregnancy testing supplies. One provider explained this as being due to pregnancy tests being conducted in the laboratory only. Another provider described stockouts of STI drugs as a challenge. While there are no specific examination couches for lithotomy, two providers acknowledged use of standard couches for examination.

Use of National Policy Standards and Service Protocols

According to the national guidelines on the management of sexual violence and the medical treatment regulations in the Sexual Offences Act, health care providers are required to clearly document the history collected from survivors; the specimens collected; details of when and to whom these were transferred; results of analysis; and clients' identifying information. These details are to be captured as stipulated within the guidelines and protocols of management. It was established that in all the facilities visited, health providers were using three types of documents as stipulated within existing guidelines and protocols. These documents include the PRC form, the Kenya Police Medical Examination (P3) form, and registers.

None of the respondents indicated 100% availability of the national guidelines and documentation protocols required in management of survivors (Table 14). This could, however, be associated with the service delivery points where the providers were drawn from, as these forms are not filled in by all providers. A small number (7%) of providers reported lacking the national guidelines on management of sexual violence, despite the guidelines' role in benchmarking of the services to be provided. While 83% of respondents indicated availability of referral forms, such forms are not commonly standard national forms but rather are forms customized by the health facility. In some instances, referrals are done verbally.

It is worth noting that the national guidelines in place are not specifically for child and adolescent survivors of sexual violence but rather are for all survivors who present to health facilities.

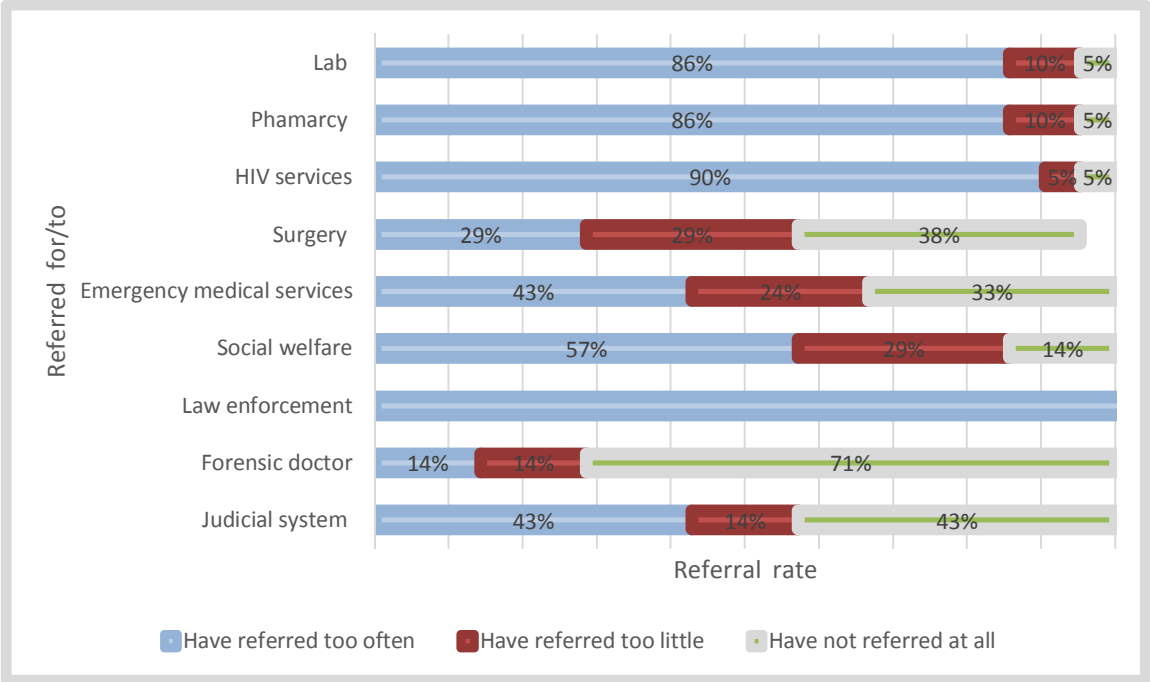
Table 14: Documentation Tools and Guidelines

Availability of	Yes N (%)	No N (%)
National sexual violence management guidelines	23 (76.7%)	7 (23.3%)
Checklists for management	18 (60%)	11 (36.7%)
Consent forms	11 (36.7%)	18 (60%)
PRC forms	29 (96.7%)	1 (3.3%)
PRC register	26 (86.7%)	4 (13.3%)
Lab register	28 (93.3%)	2 (6.7%)
Referral forms	25 (83.3%)	5 (16.7%)
National ART guidelines	28 (93.3%)	2 (6.7%)
PEP protocol	24 (80.0%)	4 (13.3%)
Counseling protocol	24 (80.0%)	6 (20.0%)
Clinical management protocol	25 (83.3%)	5 (16.7%)

Referral System and Multisectoral Linkages

Respondents were asked about the referral mechanisms in place to ensure that child/adolescent survivors of sexual violence receive comprehensive care. Figure 10 illustrates where providers currently refer survivors.

Figure 10: Referral Mechanisms



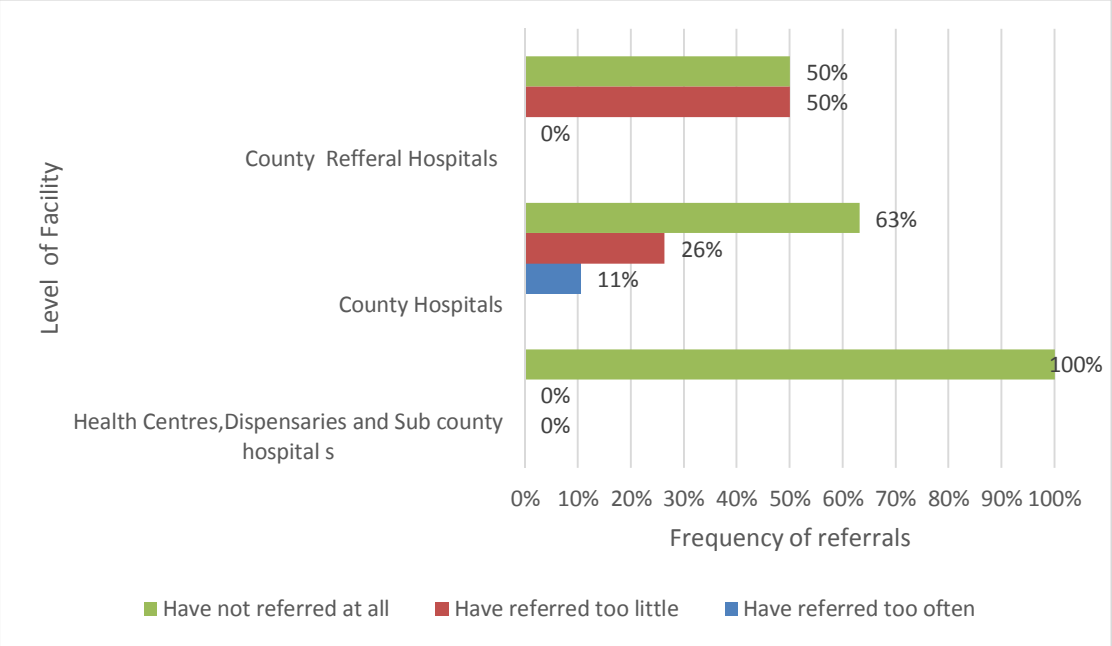
Nine providers reported that they had not offered any referrals, either because they had not attended to any survivor or because they had been transferred to a service delivery point not involved in delivery of post-rape care services. Only 14% of providers reported referring cases to forensic doctors. This could be attributed to the revised national guidelines, which allow for a

survivor to be examined by a doctor, clinical officer, and/or nurse. Over 80% of referrals were made to a laboratory, pharmacy, or HIV services.

Referrals to nongovernmental and faith-based organizations

Health facilities are meant to refer survivors for legal aid services, mostly provided by nongovernmental organizations (NGOs) and faith-based organizations (FBOs). This was not found to be the case in practice (see Figure 11). All four providers from primary care units (dispensaries and health centers) mentioned never having referred survivors to a NGO or FBO. Only 11% of providers from county hospitals reported having frequently referred survivors to NGOs/FBOs for other services. It is unclear where survivors are referred for services not available within health facilities or for nonmedical care.

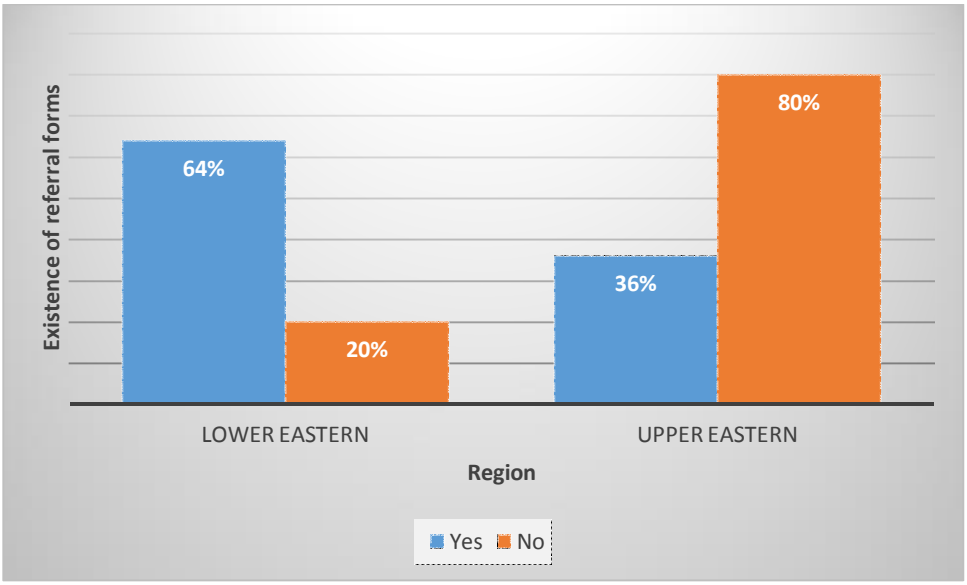
Figure 11: Referrals to NGOs and FBOs, by Facility Type



Referral forms

The national guidelines on the management of sexual violence do not provide for standardized referral forms. However, 64% and 36% of providers from the Lower and Upper Eastern regions, respectively, indicated availability of referral forms in their facilities for cases of sexual violence attended (Figure 12). It was not clear if these forms are specifically designed for cases of sexual violence.

Figure 12: Availability of Referral Forms, by Region



DISCUSSION

Provider Knowledge, Attitudes, and Perceptions

Previous studies have shown that not all facilities or departments have staff with formal training on care for survivors of sexual violence (Scott et al. 2013). Limitations in provider knowledge and perceptions about domestic violence have been identified as barriers to effective clinical management (Sugg et al. 1999). Thus, information on providers' knowledge, attitudes, and perceptions toward survivors of sexual violence, and more so, toward child and adolescent survivors can be useful in enabling health facility managers to better understand the content that should be covered in provider training programs. Moreover, this information can be used to document changes in provider knowledge, attitudes, and practices over time.

The findings of this assessment revealed considerable awareness among providers on the factors contributing to SGBV, with more than half of the providers having attended targeted training facilitated by the Ministry of Health or NGOs on sexual and reproductive health, gender-based violence, or sexual violence. This level of awareness is in accordance with evidence from other studies (Bryant and Spencer 2002). We found that a few providers still possess some conservative values (such as negative attitudes toward adolescents), which probably limits their approach to case management.

In this assessment, even providers who had been trained in management of sexual violence lacked adequate skills on how to manage child and adolescent survivors. In particular, providers lacked skills in evidence retrieval, history-taking, referral, and physical examination. For some of the trained providers, this was because they did not have opportunities to use the skills acquired. Consequently, the national curriculum currently under revision has made provisions for practicum sessions, in addition to adding a unit to address provider perceptions and attitudes. A supplemental package for training health care providers on comprehensive management has

been included in the national training curriculum, based on findings from the desk review (Part I of this report) and the training needs assessment (Part II).

Leadership and Supervision

Improving feedback mechanisms within hospitals is key in management of patients (Manongi, Marchant, and Bygbjerg 2006). However, limited evidence exists on which are the most preferred feedback mechanisms: top-down or peer-to-peer. In the majority of the facilities participating in this assessment, measures were lacking to promote supervision and mentorship of providers engaged in management of cases of sexual violence. Providers reported little or no facility-based supervision from their managers and noted that county health management teams had not been sensitized on GBV yet were required to play a supervisory role. While research demonstrates that joint problem-solving between supervisors and health providers is essential for quality improvement, no training package exists in Kenya to equip line managers and county reproductive health officers with adequate supervisory skills and expertise on sexual violence management (Loevinsohn, Guerrero, and Gregorio 1995).

Experience Attending to Child/Adolescent Survivors

The majority of providers had some experience handling adolescent or child cases of sexual violence. When further explored for their case management, most had applied generic practices such as STI prophylaxis and/or treatment, sexual health screening, HIV counseling and testing, and even evaluation and treatment of injuries. However, fewer were comfortable and had experience with specific protocols for sexual violence such as use of the Tanner stages of sexual maturation or body maps, conducting a forensic examination, trauma counseling, and vaginal/anal examinations. The Kenya national training curriculum on clinical management of sexual violence has recently been revised to include protocols and job aids to aid in management of this population group.

Equipment

The national guidelines on the management of survivors of sexual violence require all health facilities to be accessible and well equipped, but not all health facilities are well equipped to respond to the needs of survivors (Kaboru et al. 2014). In this study, providers indicated that their facilities did not have all the equipment necessary for appropriate management of survivors of sexual violence, and specifically for children and adolescents. Facilities lacked equipment and supplies essential for clinical care and prophylactic treatment, in addition to having no measures in place to facilitate proper collection (e.g., forensic and rape kits), documentation (e.g., camera), and storage of evidence and/or information obtained from survivors as outlined in the technical considerations for management of child and adolescent survivors of sexual violence document.

Referrals

Management of survivors calls for a multisectoral model across the health, social service, legal, and security sectors (Ward & Marsh, 2006). Clear referral systems are necessary to ensure survivors' needs are met comprehensively and efficiently. A clear referral system must be established in facilities or geographic locations that enable survivors to know to whom they can report and the services they can expect to receive from different institutions. Within health

facilities, the need for referrals across different levels of facilities exists. This assessment established that survivors are required to visit different service delivery points for comprehensive care, but there are no standard referral mechanisms for child and adolescent survivors of sexual violence. Information on referrals within and outside the health facilities is not well documented. Respondents reported sometimes giving verbal referrals or using written notes that are not standardized. Hence, there will be difficulties in assessing uptake of referrals and survivor access to comprehensive services. In addition, multisectoral referral of survivors is weak and not well documented. A referral system should be developed by all providers and actors involved in delivery of SGBV services.

Adherence to National Standards

The Ministry of Health has developed national guidelines on management of sexual violence, as well as training curricula and job aids. However, in all the facilities visited in this assessment, *not all the providers had seen or used these standards in management of survivors of sexual violence*. The national guidelines on management of sexual violence in Kenya do not provide clear considerations on the management of child and adolescent survivors, with a focus on clinical care and management of health risks such as HIV, pregnancy, and STIs, or informed consent procedures for parents and/or guardians and counseling services. At the international level, recognition of the unique needs of child and adolescent survivors resulted in development of technical considerations for management of child and adult survivors. However, these are yet to be adapted for the Kenyan context.

RECOMMENDATIONS

Provider Training

There is need for facilities to enhance providers' skills. This can be achieved by deploying trained staff to departments where they can use skills acquired during training over a specified period post-training. In addition, training curricula on the clinical and psychosocial management of survivors of sexual violence should be revised to ensure adaptation of the content listed in the PEPFAR Technical Considerations on Management of Child and Adolescent Survivors of Sexual Violence. IntraHealth's Learning for Performance approach (IntraHealth International 2007) should be used to promote skill-based training linked to clinical management standards and performance specifications as well as performance evaluation measures.

Given that health facilities are the first point of reporting for most SGBV cases, all health care providers ought to be trained in SGBV management regardless of the departments in which they work. This will help alleviate the challenges faced by providers who are required to offer these services without having received appropriate training. The revised SGBV training curriculum—with a dedicated chapter focusing on children and adolescents—should be piloted to ensure that the proposed training approach is more skills-based and offers providers opportunities to practice skills imparted with a focus on management of child and adolescent survivors.

Supervision

The health sector should put in place a supervision model to provide support to all providers involved in management of child and adolescent survivors of sexual violence. In addition, at the county level, measures should be put in place to mandate county reproductive health officers with the responsibility of not only overseeing delivery of services to survivors but also ensuring that facilities are well stocked with the required equipment for management of survivors.

Equipment

Measures should be put in place to facilitate adequate signage, and proper collection, documentation, and storage of evidence and information obtained from survivors. All facilities should be equipped with sexual assault evidence collection kits, referred to as "rape kits" in the national guidelines on management of sexual violence. An assessment should be undertaken of all health facilities in Kenya to determine the functionality of the equipment in the laboratory to ensure that all laboratories are stocked with optimum equipment and reagents. Health facilities should have equipment for examination and commodities to guarantee delivery of comprehensive services to child and adolescent survivors of sexual violence.

Referral

To facilitate access to comprehensive medico-legal care, there is need for referral pathways of survivors to be clearly documented and information shared with all providers to facilitate timely and efficient referrals. The referral pathways should also be sensitive to child and adolescent survivors' needs. A review of the SOPs on referral developed by the task force on implementation of the Sexual Offences Act should be done to inform development of referral job aids that are child and adolescent friendly. Broader sectoral linkages also need to be forged. Referral directories outlining services provided by different actors are essential in facilitating access to care.

National Guidelines and Standards

There is need for the Ministry of Health to facilitate adaptation of the Technical Considerations for the Clinical Management of Children and Adolescents who have Experienced Sexual Violence developed by PEPFAR to their national documents, and make sure these are distributed to health service delivery sites. The training curriculum on management of survivors should emphasize practical and skills-based training approaches and communicate performance expectations and assessment measures. These performance expectations should be communicated to health workers during SGBV training as well as on the job.

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ANNEX I: ASSESSMENT TOOL

Informed Consent Form

Dear [Service Provider]:
On behalf of the USAID-funded, IntraHealth International-led Capacity Plus and FUNZOKenya Projects, we are conducting this assessment in order to find out your perceptions and opinions and your experience on a range of topics that deal with sexual violence, gender, children and adolescents. This is, by no means, an assessment about your performance or the quality of your work. It is, however, a means to know both your own assessment on a number of issues plus the knowledge and experience you have acquired through coursework, workshops and/or your daily provision of health care services. It is important to stress that there are no right or wrong answers to the questions. You may answer them according to your best knowledge and judgment. Your participation is completely voluntary; you may choose not to participate; however, we would very much appreciate your contribution to this survey. Also, even if you choose to participate, you may stop or withdraw from completing it at any time if you so wish, and return it, without any prejudice or consequence to you. This interview will remain completely CONFIDENTIAL and we will not reveal your name or position to anyone in the organization. These records will be destroyed 6 months after the final report is written.

Do you agree to participate? ☐ Yes ☐ No

Signature of service provider: Date: /2015
Signature of Person obtaining consent/interviewer: Date: /2015

General Information

METHODS FOR ANSWERING QUESTIONS
*You will see that there are a variety of ways in which you will be asked to answer a question. There are questions were you will be asked to answer directly a "**Yes**" or "**No**" response. On other types of questions, you will be asked to read all statements before answering whether you tend to agree with one or another statement. Finally, there will be a number of questions where we will either ask you to circle how you feel about expressions or situations along a scale that usually goes from 1 = Totally Disagree; 2 = Partially Disagree; 3 = Neither Agree nor Disagree (Neutral); 4 = Partially Agree; 5 = Totally Agree. Circle that which is closer to your views. There will also be questions with a response using a **score** from 1 to 10 to judge from 1 = something inexistent, poor or low end, to 10 = being fully developed, functioning or of high level of quality. Your scores do not need to be exact, just an approximation regarding your perception of it. We will also add space where you can add more description or add any examples that may help explain your scores.*
1. Age in completed years: _____years
2. Sex (*circle*): Male Female
3. Cadre: 1 = Medical Doctor; 2 = Clinical Officer; 3 = Nurse; 4 = Midwife; 5 = Other. **If other, please write cadre here:** _____
4a). Name of facility: _____ **(as in MFL)**
4b.) Department/ work station: _____
5. County where facility is located: _____

6. Facility type (GOK, FBO, Private): _____ Level of Facility (1 2 3 or 4) ..... (Where 4-National referral, 3 County Hospital, 2-Primary care unit and 1 Community Unit)
7a). what is your current position: _____
7b). Years working in current position: _____ years
8. **Date of the Interview (dd/mm/yyyy): ___/___/_____**

SECTION I –BACKGROUND

This section relates to your background and training in the topics of RH service provision, gender, sexual violence, children and adolescents. Please answer as per the best of your knowledge and judgment

1. How many years are you working in [reproductive] health?	Years	
2. In the last 3 years how many trainings have you had on the following topics? (*Place number or tick "Not received" if none)*	NUMBER	NOT RECEIVED
2a. Reproductive Health (e.g., MNH, FP, PNC, STI)		
2b. Gender, violence against women, human rights (any)		
2c. Sexual violence (specific)		
EXPLAIN / DESCRIBE AS NEEDED, Give specific names, duration and provider of training attended		

SECTION II – LEADERSHIP AND SUPERVISION

This section inquires about leadership and supervision of sexual gender based violence of your work

3. Have the members of the facility health management team been sensitized on SGBV issues	Yes	No	DK
4. Do you have a designated member at the C/DHMT responsible for SGBV issues	Yes	No	DK
5. Do you have a designated supervisor responsible for SGBV at your facility?	Yes	No	DK
6. In the last 6 months, have you been supervised by your supervisor? *Please circle* (*If no, mark in "No" and skip to next section*). If yes, did s/he…	Yes	No	DK
a. Review your work in relation to pre-agreed goals and objectives?	Yes	No	DK
b. Reinforce any limitations in your knowledge and/or skills?	Yes	No	DK
c. Provide any feedback for you to perform your job better?	Yes	No	DK
d. Review your performance in relation to provision of clinical management of sexual violence or GBV?	Yes	No	DK
e. Provide any feedback for you to perform your duties related to clinical management of sexual violence or GBV?	Yes	No	DK

EXPLAIN			

SECTION III– PERCEPTIONS

In this section we will ask you about how you perceive certain things in relation to sexual and reproductive health. Remember, there are no "good" or "bad" answers. Answer to the best of your understanding and perception.

In your view, on a scale from 1 to 10 (1 = not prevalent; 10 = highly prevalent), how prevalent are the following situations in the communities you serve? Please circle your answer each time.

7. Poverty	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
8. Corruption of leaders	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
9. Lack of access to health for women and children	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
10. Gender inequality	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
11. Violence against women	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
12. Sexual violence/abuse against children	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
13. Sexual violence against adolescents	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

Tell us if you Agree or Disagree with the following statements, and whether Strongly or Partially:

14. God created women and men differently, so women should not expect to reach the same goals as men	Strongly agree	Partially agree	Neither	Partially disagree	Strongly disagree
15. For the same work men can be paid more than women because they are the heads of households	Strongly agree	Partially agree	Neither	Partially disagree	Strongly disagree
16. Women should be able to use contraception without the consent of their husbands/partners	Strongly agree	Partially agree	Neither	Partially disagree	Strongly disagree
17. Adolescents are too young to be asking for the use of contraceptives	Strongly agree	Partially agree	Neither	Partially disagree	Strongly disagree
18. Women who are beaten up by their husbands/partners is usually because they have done something wrong	Strongly agree	Partially agree	Neither	Partially disagree	Strongly disagree

19. There should be an equal proportion of men and women in higher positions (e.g., hospital director)	Strongly agree	Partially agree	Neither	Partially disagree	Strongly disagree
20. A child who reports being sexually abused may be telling lies or fantasies so it's OK to not believing in them at first	Strongly agree	Partially agree	Neither	Partially disagree	Strongly disagree
21. A woman who is out alone at night is provoking men	Strongly agree	Partially agree	Neither	Partially disagree	Strongly disagree

*Now let us know with which statement you tend to agree more with, A or B. Circle only the **one** you agree more with.*

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22. **Statement A:** When resources are scarce in a family, boys should be prioritized for getting educated, since they will later support their family. **Statement B:** Girls should be given the same opportunity than boys to be educated in a family, regardless of the amount of resources they have.	Agree with statement A	Agree with statement B
23. **Statement A:** In the case of child sexual violence, all efforts should be made to conduct a medical forensic examination to reveal the truth **Statement B:** In the case of child sexual violence, a medical forensic examination should only be done if the child is willing or if it's necessary for medical treatment	Agree with statement A	Agree with statement B
24. **Statement A:** In the case of child sexual violence, reporting to the police should not be a prerequisite for obtaining medical care. **Statement B:** In the case of child sexual violence, reporting to the police should always be a prerequisite for obtaining medical care.	Agree with statement A	Agree with statement B

25. Some people believe a husband is justified in hitting his wife under certain conditions. In your opinion, is a husband justified in hitting or beating his wife in the following situations:		YES	NO	DK
a) If she goes out without telling him?	a) GOES OUT	1	2	8
b) If she neglects the children?	b) NEGLECTS CHILDREN	1	2	8
c) If she argues with him?	c) ARGUES	1	2	8
d) If she refuses to have sex with him?	d) REFUSES SEX	1	2	8
e) If she burns the food?	e) BURNS FOOD	1	2	8

SECTION IV – KNOWLEDGE, SKILLS AND EXPERIENCE

Please indicate to us your level of knowledge, skills, and experience with the following topics:

26. In the last two years, have you ever attended/treated any child or adolescent who had undergone sexual violence? If so, how many cases?	Yes, ___ child cases (0-9 years)	Yes, ___ adolescent cases (10-19)		No, have not attended/treated any child or adolescent cases
27. How comfortable do you feel in your level of knowledge and/or experience in managing cases of child or adolescent sexual violence?	Very comfortable	Somewhat comfortable	Somewhat uncomfortable	Very uncomfortable
PLEASE EXPLAIN YOUR ANSWER HERE				

28. *Now I will ask you if you know how to do the following procedures for cases of [child-adolescent] sexual violence* (*Circle "Yes" or "No" for each one)*		
a. Pregnancy testing / emergency contraception (as needed)	Yes	No
b. HIV counseling and testing and PEP (as needed)	Yes	No
c. Prophylaxis/treatment for STIs	Yes	No
d. Sexual health screening	Yes	No
e. Hepatitis B /tetanus vaccination	Yes	No
f. Forensic examination	Yes	No
g. Evaluation and treatment of injuries (as needed)	Yes	No
h. Trauma counseling	Yes	No
i. Mental health or psychosocial assessment	Yes	No
j. Referral to police and support services (psychological, social)	Yes	No
k. Management of forensic exam samples, medical record, and other evidence before transmission to the police	Yes	No
EXPLAIN IF NEEDED		

29. How familiar are you or have used the following? *Please circle*	Very familiar / have used often	Not very familiar / have used little	Not familiar / have not used at all
a. Vaginal and anal examination of the pre-pubertal female	1	2	3

b. Genital and anal examination of the male	1	2	3
c. Collection of evidence (i.e. oral, fingernail, genital anorectal swabs)	1	2	3
d. Tanner stages of sexual maturation	1	2	3
e. Use of informed consent and patient rights' framework	1	2	3
f. "Head-to-toe" physical examination	1	2	3
g. The ten features of physical injuries (e.g. type, site, size, color, borders)	1	2	3
h. Use of "body maps" (Post Rape Care/ PRC forms)	1	2	3
EXPLAIN IF NEEDED			

SECTION V INFRASTRUCTURE

Please indicate the infrastructure you have at the facility to provide SGBV services

30. Do you have adequate physical environment for managing cases of sexual violence? *Please circle after each one*		
a. System to store sensitive patient images securely & confidentially	Yes	No
b. Access to a functional laboratory with the capacity to carry out tests required for rape survivors	Yes	No
c. Adequately lit clinical/examination rooms	Yes	No
d. Lockable cupboard for storage of forensic/medico-legal evidence	Yes	No
e. Clear directions/signs posted within the facility	Yes	No
f. Running water	Yes	No
EXPLAIN IF NEEDED		

SECTION V EQUIPMENT SUPPLIES AND STORAGE

Please indicate the equipment supplies you have at the facility to provide SGBV services

31. Do you have the minimum equipment necessary for managing cases of sexual violence? *Please circle after each one*		
a. Examination table for lithotomy (position)	Yes	No
b. Powder-free non-sterile exam gloves	Yes	No
c. Specula for post-pubertal children ONLY	Yes	No
d. Culture supplies	Yes	No
e. Lubricants	Yes	No
f. Pre-packaged rape kit or evidence collection kits	Yes	No
g. Forensic supplies: paper bags, evidence tape for sealing bags, container, cotton tipped swabs, tape measure, etc.	Yes	No

h. Digital camera	Yes	No
i. Handheld magnifying glass	Yes	No
j. Working angle lamp	Yes	No
k. Sanitary towels	Yes	No
l. Patient gowns	Yes	No
m. Pregnancy test available in the examination room	Yes	No
n. Rapid HIV test materials	Yes	No
o. Post-exposure prophylaxis drugs	Yes	No
p. Emergency contraception	Yes	No
q. STI drugs	Yes	No
r. Needles	Yes	No
s. Syringes	Yes	No
t. Vercutainer	Yes	No
u. Antiemetic's (anti-nausea and vomiting drugs)	Yes	No
v. Sharps container	Yes	No
w. Lined bin for disposal of contaminated wastes (gloves, cotton wool, etc.)	Yes	No
	Yes	No
EXPLAIN IF NEEDED		

SECTION VI STANDARDS AND POLICY GUIDELINES

Please indicate the standards and policy guidelines you observe in providing SGBV services

32. Do you have written job descriptions, standards, job aids, specifically…? *Please circle after each one*		
a. National guidelines on management of sexual violence in Kenya (2012)	Yes	No
b. Checklists/guidelines for management of sexual violence	Yes	No
c. Consent form for forensic examination	Yes	No
d. Post-rape care (PRC MOH 363) Forms	Yes	No
e. Post-rape care (PRC) register	Yes	No
f. Laboratory register	Yes	No
g. Referral forms	Yes	No
h. National ART guidelines	Yes	No
i. Post-exposure prophylaxis (PEP) protocol	Yes	No
j. Counseling protocol	Yes	No
k. Clinical management protocol	Yes	No
EXPLAIN IF NEEDED		

SECTION VI REFERRAL SYSTEM AND MULTISECTORAL LINKAGES

Please answer the following questions on the referral system and multi sectoral linkages at your facility

33. Have you referred patients to the following for services related to sexual violence within or outside the health sector? *Please circle*	Have referred too often	Have referred too little	Have not referred at all
a. Judicial system (e.g., courts, prosecution of sexual violence cases)	1	2	3
b. Forensic doctor (if applicable	1	2	3
c. Police/law enforcement (e.g., police, probation officers)	1	2	3
d. Social welfare services (e.g., child protective services, psychosocial support, individual and/or family counseling, parenting training, survivors' groups)	1	2	3
e. Emergency medical services	1	2	3
f. Surgery	1	2	3
g. Maternity	1	2	3
h. Advocacy (media, NGO's etc.)	1	2	3
i. HIV services (e.g., ongoing treatment, follow-up testing, side effect management)	1	2	3
j. Community health	1	2	3
k. Pharmacy	1	2	3
l. Laboratory (testing and evidentiary)	1	2	3
m. NGOs/faith-based organizations	1	2	3
Other sector? Fill in name of sector here: _____	1	2	3
EXPLAIN IF NEEDED			

Thank you very much for your time and answers to these questions! Have a good day!

ANNEX II: LIST OF HEALTH FACILITIES SAMPLED

No.	Name of health facility	Type of facility	County
1	Akachiu Health Centre		Meru
2	Athi River Health Centre		Machakos
3	Chuka County Hospital	4	Tharaka Nithi
4	Embu County Referral	5	Embu
5	Kangundo District Hospital	4	Machakos
6	Kibwezi Sub County Hospital	3	Makueni
7	Kitui County Hospital	4	Kitui
8	Makueni County Hospital	4	Makueni
9	Machakos County Hospital	5	Machakos
10	Makindu County Hospital	4	Makueni
11	Miathene Sub County Hospital	4	Meru
12	Matuu Sub County Hospital	3	Machakos
13	Mbeere Sub County Hospital	3	Embu
14	Meru Training & Referral	5	Meru
15	Mwingi County Hospital	4	Kitui
16	Nyambene Sub County Hospital	3	Meru
17	Magutini Sub-County Hospital		Tharaka Nithi
18	Yatta Sub-County Hospital	3	Machakos

ANNEX III: LIST OF RESOURCES AND EQUIPMENT NECESSARY FOR PRC SERVICE DELIVERY

Examination Site Set Up	
1.	An appropriate location for private examination
2.	Resources to create an aesthetically child friendly environment available
3.	Proper lighting, soap and water and toilet facilities
4.	A staffing plan that encourages availability of trained health care professional, 24hrs per day
Equipment needed	
5.	Examination table for the clinician and 3 seats.
6.	Powder free non-sterile examination gloves
7.	Examination couch that allows for lithotomy position
8.	Specula- for post pubertal children only
9.	Culture supplies
10.	Lubricants
11.	Evidence collection kit
12.	Forensic supplies
13.	Sharps disposal container
14.	Water for injection, normal saline
15.	Patients gowns , bed linen/sheets
16.	Basic medical supplies for injury treatment- sutures, bandages, splints, scissors
17.	Patient comfort suppliers- sanitary towels, food, drinks, toiletries and any extra clothing/under garments
18.	Resuscitation equipment's
19.	Digital camera and related supplies such as memory cards, batteries, flash and a ruler
20.	Hand held magnifying glass
21.	Access to autoclave for sterilizing equipment's if necessary
22.	Laboratory facilities/testing access
23.	Weighing scale, height chart and tape measure

APPENDIX 4. MODULE 6: MANAGEMENT OF SEXUAL VIOLENCE IN CHILDREN AND ADOLESCENTS (EXCERPT FROM REVISED NATIONAL SGBV CURRICULUM FACILITATOR'S MANUAL)

Module 6

Management of Sexual Violence in Children and Adolescents

Module 6: Management of sexual violence in Children and Adolescents

Purpose/Module Competence:

To attain the competence to attend to children and adolescents survivors of sexual gender based violence.

Expected Learning Outcomes:

By the end of this module the participant should be able to:

1. Prepare children and adolescent survivors of SGBV for clinical management, informed consent and assent
2. Take comprehensive history from a guardian/care giver and a survivor
3. Perform a thorough physical examination and assess the psychosocial status of children and adolescent survivors
4. Investigate and collect forensic evidence
5. Provide appropriate treatment and counselling
6. Manage follow up sessions and refer appropriately

Content:

Unit 1: Key principles for Working with Children and Preparation for Management of Children and Adolescents.

- A safe and trusting environment for the interview and eventual examination
- Promote the child's best interest
- The rule of confidentiality
- Informed consent/assent
- Psychosocial assessment

Unit 2: Taking History

- History taking
- Survivor child and adolescent centred approach to obtaining history
- Psychosocial history taking

Unit 3: Physical Examination and Psychological Assessment

- General physical examination
- Systemic examination
- Psychological assessment
- Documentation of findings

Unit 4: Investigation and Forensic Management

- Collection of evidence for clinical management
- Collecting handling, preserving evidence for legal purposes
- Documentation for management and legal purposes

Unit 5: Treatment and Counselling

- Management of life threatening and other injuries
- Pregnancy Prevention and management
- Prevention of HIV
- STIs prophylaxis and treatment
- Hepatitis B prevention
- Psychosocial Support

- Documentation of treatment on PRC form and SGBV register

Unit 6: Follow up Care and Referral

- Referrals
- Referral Mechanism
- Follow up
- Feedback
- Key Actors and services available for children and adolescent survivors

UNIT 1: KEY PRINCIPLES FOR WORKING WITH CHILDREN AND PREPARATION FOR MANAGEMENT OF CHILDREN AND ADOLESCENTS.

Purpose:

Establish a child-friendly environment and create rapport with survivor and care-giver

Expected Learning Outcomes

By the end of the unit participants should be able to;

1. Create a safe and trusting environment for the interview and eventual examination
2. Apply the rule of confidentiality
3. Inform survivors about available services while respecting the survivors right of choice of services
4. Obtain Informed consent and assent

Lesson Plan Guide:

Time: 40min

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
10 mins	**Key Principles of working with Children** - Best interest of	Discuss the key principles of working with children	Brainstorming, illustrated lectures	AIDSTAR-One, Technical Considerations

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	the child - Ensure child safety - Treat every Child fairly and equally			2013
10 mins	**Requirements of an ideal/safe interview and examination room** - Warm conducive environment - Children and adolescent rights - equipment and supplies - Privacy of the room - Key principles of managing a child	Discuss requirements of an ideal interview and examination room	Brainstorming, illustrated lectures	National Guidelines, LCD, Flip chart paper, marker pens, ECSA, AIDSTAR-One, Technical Considerations 2013

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
10 Mins	**Privacy and Confidentiality** - Treat children and adolescents with respect and dignity - Greetings & self-introduction - Reassure the survivors - Privacy and confidentiality - Shared confidentiality	Discuss privacy and confidentiality	Brainstorming/Q&A, illustrated lectures Role plays/Practical session	National Guidelines, LCD, Flip chart paper, marker pens, ECSA, AIDSTAR-One, PEPFAR Technical considerations, Trainers guide on Clinical of management of Sexual Violence 2011
10 mins	**Obtaining informed consent / assent** Explaining what is informed consent/assent - Importance of obtaining informed consent/assent in managing a survivor - Procedure of informed	Explain how to obtain informed consent Practical session to practice mastery of skills	Group discussions Demonstration, Role plays,	National Guidelines, LCD, Flip chart paper, marker pens, ECSA, AIDSTAR-One, Trainers guide on Clinical of management of Sexual Violence 2011

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	consent - Challenges in obtaining informed consent/assent			

Facilitator's notes

Requirements of an ideal examination room

For a child friendly room walls be coloured with atttractive colours,drawings on the walls toys,mats,calour pensils,drawing paper and well light .It should be clean and safe

Equipment

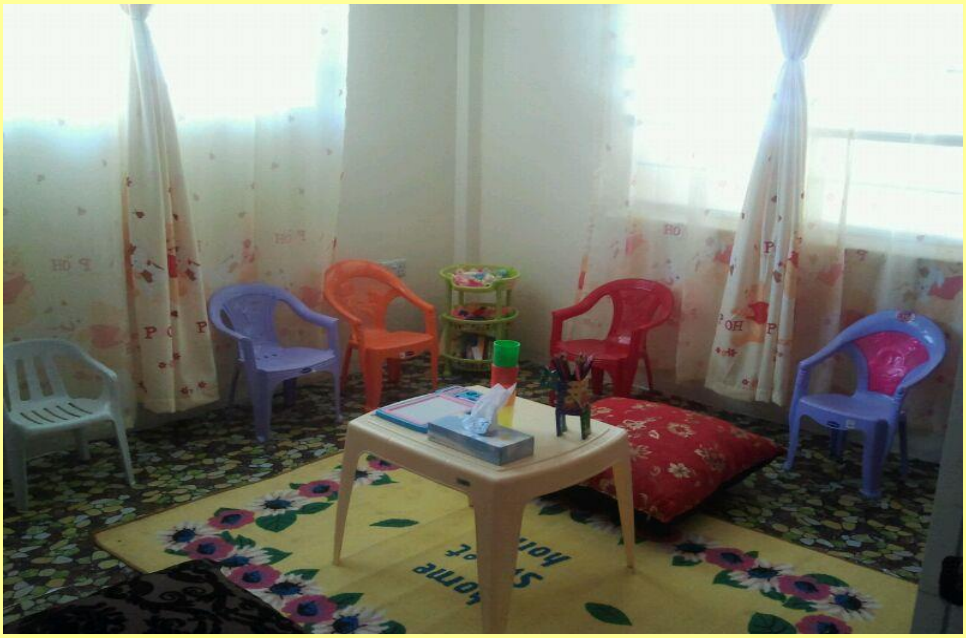
Lockable cupboard for specimens and equipments

Lockable cabinets for documents

Room for the adolescents;TV, books, IEC materials

Medical forensic examinations should take place at a medical site where there is optimal access to the full range of services that may be required by the child. This requires overall site preparation, examination site set up and equipment's.

A child friendly room



An adolescent friendly room

Treat the survivor with respect and dignity throughout the entire examination irrespective of their social status, race, religion, culture, sexual orientation, lifestyle, sex or occupation

- Greet the survivor by her/his preferred name: this will make her/him your central focus
- Introduce yourself to the patient and tell her/ him your role, i.e. physician, nurse, health worker, counsellor
- Aim for a respectful attitude and be quite professional within the boundaries of your patient's culture
- Have a calm demeanour; a survivor who has experienced fear wants to be in the company of people who are not frightened
- Be unhurried; give time Maintain eye contact as much as is culturally appropriate
- Secure physical and emotional safety (well-being) throughout care and treatment
- Evaluate positive and negative consequences of actions with participation of the child and caregiver (as appropriate)
- The least harmful course of action is always preferred
- All actions should ensure that the child's/adolescent rights to safety and ongoing
- development are not compromised

Guiding Principles for Caring for Children Who Have Experienced Sexual Violence (AIDSTAR – One Feb, 2010)

Promote the child's best interest

- Secure physical and emotional safety (well-being) throughout care and treatment
- Evaluate positive and negative consequences of actions with participation of the child and caregiver (as appropriate)
- The least harmful course of action is always preferred
- All actions should ensure that the child's rights to safety and ongoing development are not compromised

Ensure the safety of the child

- Ensure physical and emotional safety

- All actions should safeguard the child's physical and emotional well-being in the short and long term

Comfort the child

- Offer comfort, encouragement, and support
- Assure that service providers are prepared to handle the disclosure of sexual violence and exploitation appropriately
- Believe the child when they have chosen to disclose sexual violence and exploitation
- Never blame the child in any way for the sexual violence and exploitation they have experienced
- Make the child feel safe and cared for as they receive services

Ensure appropriate confidentiality

- Information about the child's experience of sexual violence and exploitation should be collected, used, and stored in a confidential manner
- Ensure the confidential collection of information during all aspects of care including interviews and history taking
- Share information only according to local laws and policies and on a need to-know basis, after obtaining permission from the child and/or caregiver
- Store all case information securely
- If mandatory reporting is required under local law, inform the child and caregiver at the time they are seen
- If the child's health or safety is at risk, there may be limits to confidentiality to protect the child

Involve the child in decision making

- Children have a right to participate in decisions that have implications in their lives
- The level of a child's participation in decision making should be appropriate to the child's level of maturity and age, and local laws
- Although service providers may not always be able to follow the child's wishes (based on best-interest considerations), they should always empower and support children and deal with them in a transparent, open manner with respect

- If a child's wishes are not able to be followed, then the reasons behind not being able to follow them should be explained

Treat every child fairly and equally

- Utilize the principle of non-discrimination and inclusiveness for all children
- All children should be offered the same high-quality care and treatment, regardless of their ethnicity, religion, sex, ability/disability, family situation, status of their parents or caregivers, cultural background, or financial situation, affording them the opportunity to reach their full potential
- No child should be treated unfairly for any reason

Strengthen children's resiliencies

- Each child has unique capacities and strengths, and possesses the capacity to heal
- Identify and build upon the child's and family's natural strengths as a part of the recovery and healing process
- Factors that promote the child's resilience should be identified and built upon during the episode of care
- Children who have caring relationships and opportunities for meaningful participation in family and community life and who see themselves as strong will be more likely to recover and heal from sexual violence and exploitation

Health care providers should be appropriately trained and skilled in managing children who have experienced sexual violence and exploitation.

All providers responsible for caring for children who have experienced sexual violence and exploitation should:

- Undergo training and orientation to the sexual violence/post-rape care clinic and referral protocols
- Have specialized training on the medical forensic examination

- Have advanced training on and understanding of emergency contraception based on national laws and protocols, where applicable and legal, as well as HIVnPEP, STI prophylaxis, hepatitis B vaccination, and the importance of timely intervention
- Health care centres should:
- Identify and train dedicated practitioners (doctors, forensic nurses, or clinic officers) to provide post-rape care and services for children

The health and welfare of the child takes precedence over the collection of evidence

- Crisis intervention; treatment of serious injuries; and assessment, treatment, and prevention of HIV, pregnancy, and STIs are of primary importance
- The welfare of the child ensures that they are able to maintain their dignity after sexual violence and exploitation, and do not feel coerced, humiliated, or further traumatized by the process of seeking services
- Children should NEVER be forced to undergo the medical forensic examination against their will unless the examination is necessary for medical treatment.

Reporting to police should not be a prerequisite for obtaining medical care

- The child's decision regarding police involvement should be respected at all times
- The child should not be pressured, coerced, or forced to report the sexual violence and exploitation as a condition of receiving their medical care
- It is common for health care workers to tell the child that a police report must be made and they must obtain the report form before the facility will conduct the examination
- Reporting is often tied to payment of fees, the hospital may only agree to provide free services if the patient has reported the violence to the police and is in possession of the official documentation forms. In most cases, these are procedural rather than legal requirements and should be changed at the facility level.
- Efforts should be made by the facility to have a clear policy on reporting, consistent with national policy that affords the most patient-centered approach
- Police forms should be kept ideally at the facility for children who present to the facility first and should be available free of charge

- The child should be offered all available services including emergency contraception (EC) where legal, HIVnPEP, and other needed health services even if there is no physician available to sign medico legal forms, or if the child chooses not to report to the police

Use the person-first approaches to care

- Professionals working with children who have experienced sexual violence and exploitation must have a strong understanding of current approaches to inclusive care of all patients regardless of ability
- Recognize that children with disabilities (physical as well as mental/emotional) are at increased risk for sexual violence and exploitation, and have equal right to care and access treatment
- Ensure that someone who is trained is available when necessary for communication alternatives (e.g., sign language) for patients who may require this approach

Informed consent and Assent

Before a full medical examination of the survivor can be conducted, it is essential that informed consent is obtained by ensuring that the survivor fills the consent form or orally s/he cannot write or is impaired. This is the decision the survivor makes after a HCW has explained all aspects of clinical management on whether or not to continue with the management. There is a need to emphasize on shared confidentiality

Examining a survivor without consent could result in HCW being charged with offences of assault and trespass of privacy

- Be empathetic and non-judgmental as your patient recounts her/his experiences
- Reassure the survivor that the examination findings will be kept confidential unless she decides to bring charges
- Review the consent form with the survivor. Make sure she understands everything in it, and explain that she can refuse any aspect of the examination she does not wish to undergo. Explain to her that she can delete references to these aspects on the consent form.
- Once you are sure the survivor understands the form completely, ask her to sign it. If she cannot write, obtain a thumb print together with the signature of a witness.

Informed consent /assent guidelines (IRC 2012)

Age Group (Years)	Child	Caregiver	If No Caregiver Or Not In Child's Best Interest	Means
0-5	-	Informed Consent	Other trusted adultõs or case-workerõs informed consent	Written Consent
6-11	Informed Assent	Informed Consent	Other trusted adultõs or case workerõs informed consent	Oral Assent, Written Consent
12-14	Informed Assent	Informed Consent	Other trusted adultõs or childõs informed assent. Sufficient level of maturity (of the child) can take due weight.	Written Assent, Written Consent
15-18	Informed Consent	Obtain informed consent with childõs permission	Childõs informed consent and sufficient level of maturity takes due weight	Written Consent

References and Recommended Reading

1. AIDSTAR-One. (Feb. 2012) The Clinical management of Children and Adolescents who have Experienced Sexual Violence; *Technical Considerations for PEPFAR Programs*.

2. World Health Organization. (2003). *Guidelines for medico-legal care for victims of sexual violence*. Geneva, Switzerland: Gender and Women's Health, Family and

Community Health Injuries and Violence Prevention, Non-communicable Diseases and Mental Health

3. Ministry of Health. (2014). National Guidelines on Management of Sexual Violence (3rd Edition). Kenya

4. MOH (2014) National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya. Nairobi, Kenya: German development Cooperation

5. International Rescue Committee (2012) Caring For Survivors of Sexual Abuse. New York USA. IRC

UNIT2: HISTORY TAKING

Purpose

Obtain routine, background information and medical symptoms resulting from sexual violence.

Expected Learning Outcomes

By the end of the unit participants should be able to;

1. Take history according to standard operating procedures for children and adolescent
2. Demonstrate survivor, child and adolescent centred interview skills in obtaining history
3. Take psychosocial history according to standard operating procedures for children and adolescents

Lesson Plan Guide:

Time: 1 hour

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
20 Min	**History taking** - Purpose of history in relation to	- Describe the purpose and procedure of history taking	Brainstorming, illustrated lectures, case studies,	National Guidelines, SOPs, LCD, Flip chart paper, marker pens,

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	SGBV - Procedure of history taking - Procedure for taking gynaecological history for girls and examination - Procedure for psychosocial assessment - Documentation -filling PRC form	- Fill the PRC form Correctly and Completely	Video, role plays, Check list, guided practice	ECSA,PRC form, Trainers guide, AIDSTAR-One PEPFAR Technical Considerations
30Mins	**Child and adolescent centered approach of obtaining history** - History taking according to Developmental stage - Tanners staging	Discuss survivor, child and adolescent centered approach to history taking Practice history taking embracing this approach	Illustrated Lectures, group discussions, Role play, case studies, check lists	National Guidelines, LCD, Flip chart paper, marker pens, ECSA, AIDSTAR-One
10 min	**Psychosocial History** Family and	Take psychosocial history	Mini Lecture, Discussions	National Guidelines, SOPs, LCD, Flip chart paper, marker

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	community support			pens, ECSA,PRC form, Trainers guide, AIDSTAR-One

Facilitator's notes

History Taking for Children and adolescents

- The purpose of history-taking is to obtain routine, background information relating to the medical history of the child, as well as information about any medical symptoms that have arisen, or may result from, the abuse.
- It is important for the health worker to create a safe and trusting environment for the interview and eventual examination.
- History should be obtained from a caregiver, or someone who is acquainted with the child, rather than from the child directly; however, this may not always be possible. Nonetheless, it is important to gather as much medical information as possible.
- Older children, especially adolescents, are frequently shy or embar¬rassed when asked to talk about matters of a sexual nature.
- It is a good idea to make a point of asking whether they want an adult or parent present or not; adolescents tend to talk more freely when alone.
- History-taking from children, particularly the very young, requires special skills.
- Health Care providers should try to establish the child's developmental level in order to understand any limitations as well as appropriate interactions.

- When gathering history directly from the child it may be worth starting with a number of general, non-threatening questions, for example, “What standard are you in at school?” and “How many brothers and sisters do you have?” before moving on to cover the potentially more distressing issues.
- Be non-leading, non-suggestive and document all information as close to verbatim as possible, including observations, interactions, and emotional states of the child and his/her family.

General approach:

- Always ensure patients privacy.
- Approach all children with extreme sensitivity and recognize their vulnerability.
- Try to establish a neutral environment and rapport with the child before beginning the interview
- Try to establish the child’s developmental level in order to understand any limitations as well as appropriate interactions. It is important to realize that young children have little or no concept of numbers or time and that they may use terminology differently from adults making interpretation of questions and answers a sensitive matter
- Stop the examination if the child indicates discomfort or withdraws permission to continue; always prepare the child by explaining the examination and showing equipment; this has been shown to diminish fears and anxiety
- Encourage the child to ask questions about the examination
- If the child is old enough, and it is deemed appropriate, ask whom they would like in the room for support during the examination. Some older children may choose a trusted adult to be present
- Always identify yourself as a helping person
- Ask the child if s/he knows why s/he has come to see you.

- Establish ground rules for the interview, including permission for the child to say s/he doesn't know, permission to correct the interviewer, and the difference between truths and lies
- Ask the child to describe what happened, or is happening, to them in their own words (where applicable)
- Always begin with open-ended questions. Avoid the use of leading questions and use direct questioning only when open-ended questioning/free narrative has been exhausted. Structured interviewing protocols can reduce interviewer bias and preserve objectivity
- Consider interviewing the caretaker of the child without the child presence.
- Before proceeding, ensure that consent/assent has been obtained from the child and/or the caregiver. If the child refuses the examination, it would be appropriate to explore the reasons for the refusal. Consider examining very small children while on their mother's (or carer's) lap or lying with her on a couch. If the child still refuses, the examination may need to be deferred or even abandoned. Never force the examination, especially if there are no reported symptoms or injuries, because findings will be minimal and this coercion may represent yet another assault to the child. Consider sedation or a general anesthetic only if the child refuses the examination and conditions requiring medical attention, such as bleeding or a foreign body, are suspected

History-taking is distinct from interviewing the child about allegations of sexual abuse. Ideally, history should be obtained from a caregiver, or someone who is acquainted with the child, rather than from the child directly; however, this may not always be possible. Nonetheless, it is important to gather as much medical information as possible. Older children, especially adolescents are often shy or embarrassed when asked to talk about matters of a sexual nature. It is a good idea to make a point of asking whether they want

an adult or parent present or not; adolescents tend to talk more freely when alone. When gathering history directly from the child, start with a number of general, non-threatening questions before moving on to cover the potentially more distressing issues.

- What grade are you in at school?"
- How many brothers and sisters do you have?"

The following pieces of information are essential for medical history:

Å When do you say this happened?

Å When is the first time you remember this happening?

Å Threats that were made?

Å What area of your body did you say was touched or hurt?

Å Do you have any pain in your bottom or genital area?

Å Is there any blood in your panties or in the toilet?

Å Any difficulty or pain with voiding or defecating?

Å First menstrual period and date of last menstrual period (girls only)?

Å Details of prior sexual activity.

Å History of washing/bathing since assault

When the history has been completed, the health¬care provider can help the child to prepare for the examination by discussing the procedures, assuring the child that the examination is intended to ensure he/she is "all right," and that no part of the body has been harmed.

History taking according to the developmental stage and children with special needs and circumstances

Developmental Stage Considerations for History-Taking

Infants/toddlers/preschool (birth to 4 years old)

- Children in this age group have limited to no verbal skills and should not be asked to provide any history (see communication techniques above).
- Non-offending caregivers or adults presenting with the child for care are the primary sources of information about the child and suspected sexual violence and exploitation.

School-aged children (5–9 years old)

- Children in this age range should provide a history whenever possible.
- Caregivers, parents, and guardians may provide supplemental information but should not be involved in the history-taking unless the child refuses to separate.
- Providers should use non-leading language

Early and later adolescents (10–18 years old)

- Children in this age range should provide their own history.
- Caregivers, parents, and guardians should not be involved in the history-taking to allow the child to express their own viewpoint on what has happened to them.
- Parents or guardians can inhibit this age group from sharing all information.

The child who will not speak

- If a child cannot or will not speak to the provider, the provider should continue to talk with the child, and explain all of the examination process, but have no expectation that the child will give them a history.
- It is not unusual for a child who initially will not speak to begin speaking as the examination progresses, and they begin to feel more comfortable with the examiner.
- It is possible that children may present that have not experienced sexual violence and exploitation.

- Some children may not be willing to talk about the sexual violence and exploitation—forcing them to talk about this is traumatizing and should not be done.

Children with disabilities

- Children with disabilities should be communicated with in the manner in which they are most comfortable (e.g., sign language, Braille, plain language/pictures, or audio aids).
- It should never be assumed that because a child has some form of disability that they are not capable of communication.
- Some disabilities affect the way that children and adolescents communicate. It can be difficult to understand them, and difficult for them to understand others, which can also lead to misunderstandings that further impede comprehension.
- It is important to remember that children with disabilities are at greater risk of sexual violence and exploitation.
- It is important to respect that some children with disabilities may not wish to have the physical exam as they may not want to share or expose their body with a stranger.
- It is important to consider the best interest of the child and not use force when a child with disabilities may not be able to communicate on their own.

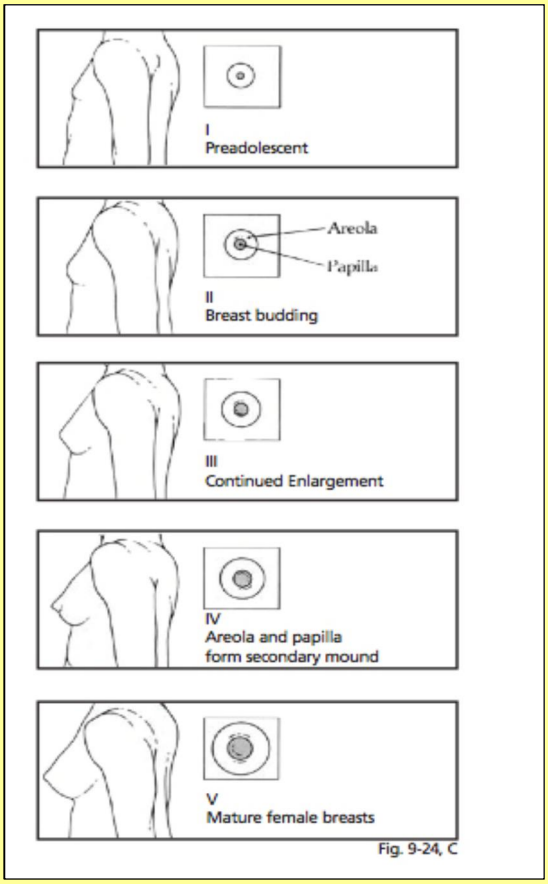
Female genital mutilation/cutting (FGM/C)

Children who have undergone FGM/C should be examined just as those without.

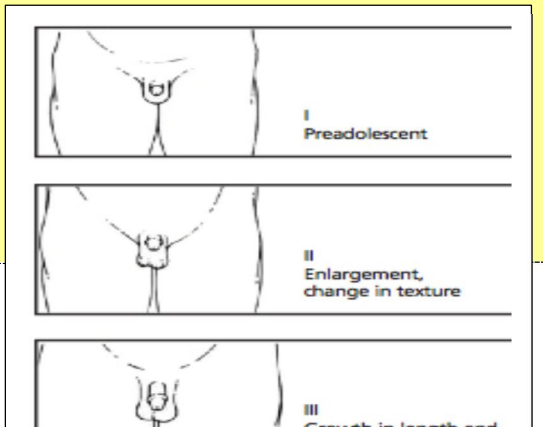
TANNER STAGES OF SEXUAL MATURATION (AIDSTAR one, 2012)

In young women, the Tanner stages for breast development are as follows

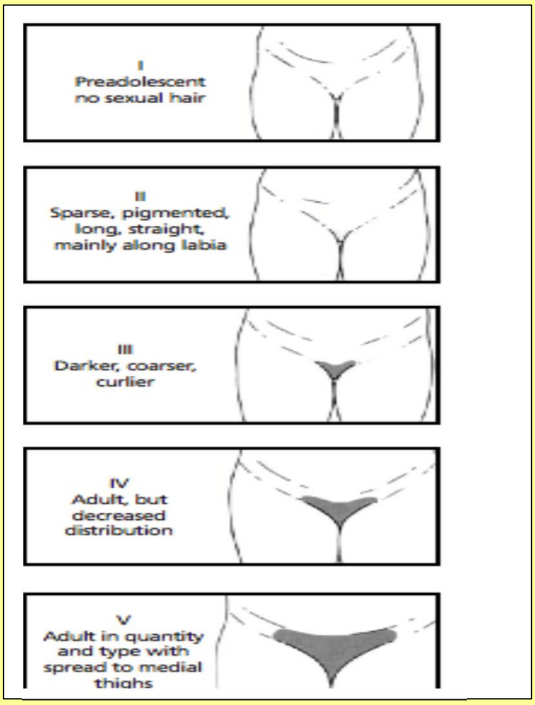
- Stage I (Preadolescent) – Only the papilla is elevated above the level of the chest wall.
• Stage II (Breast Bubbling) – Elevation of the breasts and papillae may occur as small mounds along with some increased diameter of the areolae.
• Stage III – The breasts and areolae continue to enlarge, although they show no separation of contour
• Stage IV – The areolae and papillae elevate above the level of the breasts and form secondary mounds with further development of the overall breast tissue.
• Stage V – Mature female breasts have developed. The papillae may extend slightly above the contour of the breasts as a result of the recession of the areolae.



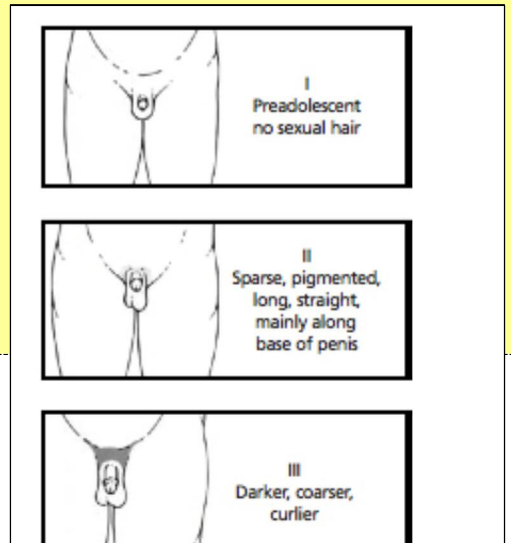
The stages for male genitalia development are as follows:
• Stage I (Preadolescent) – The testes, scrotal sac, and penis have a size and proportion similar to those of early childhood.
• Stage II – There is enlargement of the scrotum and testes and a change in the texture of the scrotal skin. The scrotal skin may also be reddened, a finding not obvious when viewed on a black and white photograph.
• Stage III – Further growth of the penis has occurred, initially in length, although with some increase in circumference. There is also increased

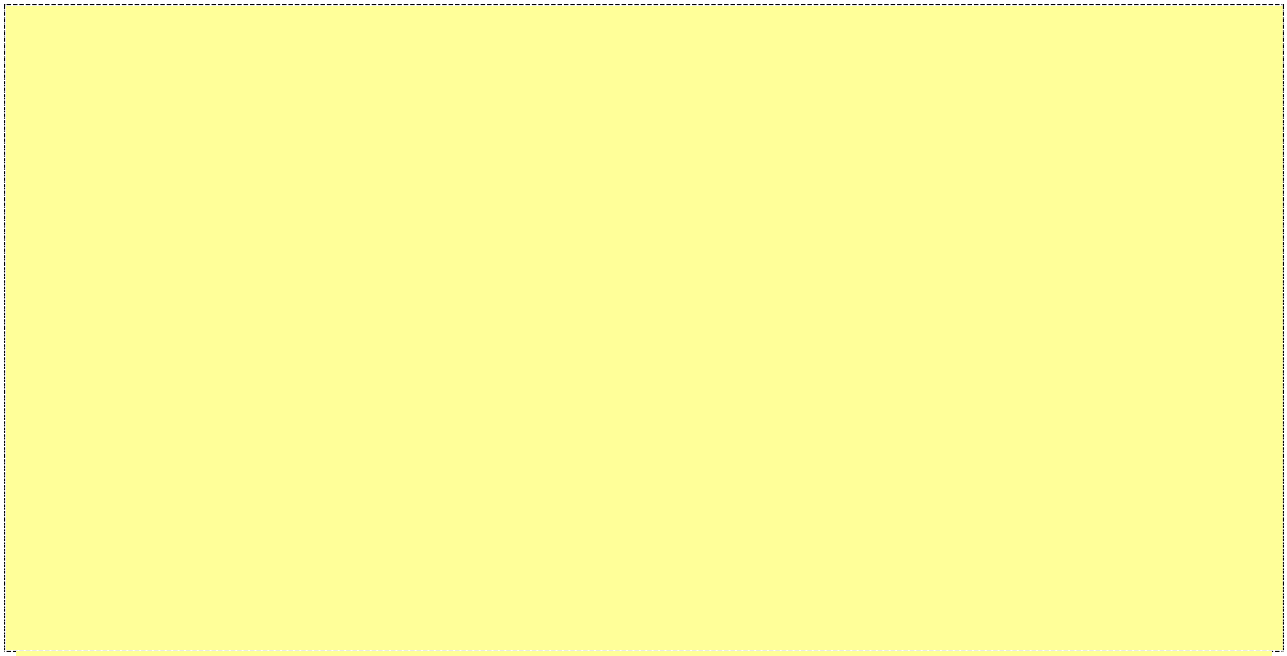


Pubic hair growth in females is staged as follows;
ÅStage I (Preadolescent) – Vellos hair develops over the pubes in a manner not greater than that over the anterior wall. There is no sexual hair.
ÅStage II – Sparse, long, pigmented, downy hair, which is straight or only slightly curled, appears. These hairs are seen mainly along the labia. This stage is difficult to quantitate on black and white photographs, particularly when pictures are of hair-haired subjects.
ÅStage III – Considerably darker, coarser, and curlier sexual hair appears.The hair has now spread sparsely over the junction of the pubes.
ÅStage IV – The hair distribution is adult in type but decreased in total quantity. There is no spread to the medial surface of the thighs.
ÅStage V – Hair is adult in quantity and type and appears to have an inverse triangle of the classically feminine type. There is spread to the medial surface of the thighs but not above the base of the inverse triangle.



The stages in male pubic hair development are as follows:
• Stage I (Preadolescent) – Vellos hair appears over the pubes with a degree of development similar to that over the abdominal wall. There is no androgen-sensitive pubic hair.
• Stage II – There is sparse development of long pigmented downy hair, which is only slightly curled or straight. The hair is seen chiefly at the base of penis. This stage may be difficult to evaluate on a photograph, especially if the subject has fair hair.
• Stage III – The pubic hair is considerably darker, coarser, and curlier. The distribution is now spread over the junction of the pubes, and at this point that hair may be recognized easily on black





Psychosocial History Taking

- Child survivors - the dynamics of child sexual abuse differ from those of adult sexual abuse in that; Children rarely disclose sexual abuse immediately after the event. Disclosure tends to be a process rather than a single episode and is often initiated following a physical complaint or a change in behaviour. Helpers should therefore:
- Develop a sense of trust, safety in the therapeutic setting a component of a working alliance- cooperation.
- Understand the child's perception of the abuse. Let them be aware of what has happened and the impact.
- Show sensitivity in handling of disclosure of diagnosis. Secrecy brings in dilemma for the child. Remember children want to remain loyal. If there is a lot of fear and/or pain, give reassurance.
- Establish a safe environment - this refers to a sense of trust. Learn to tolerate delays and frustration.
- Let the child know that you have a positive alliance with the positive care giver- this gives a sense of safety.
- Create rapport, let the child go at her/his own pace and listen carefully.
- The Helper should be aware of the developmental stage of the child.

Children and Adolescents with a disability

- Helpers need to be aware that people with developmental disabilities and have been sexually abused have challenges to "work through" or talk about their traumatic experiences in a treatment or therapeutic setting.
- It is therefore very important that the helper practice patience and like with child survivors, believe the client; impact of the abuse should not be questioned.
- Helpers should not have prejudices about people with disabilities; for example, about the benefit of psychotherapy for people with mental retardation.

- Guardians may also need assistance as caretakers of the abused;
- Helpers should debrief the guardian and/or family members and make appropriate referrals.

References and Recommended Reading

1. AIDSTAR-One. (Feb. 2012) The Clinical management of Children and Adolescents who have Experienced Sexual Violence; *Technical Considerations for PEPFAR Programs*.
2. World Health Organization. (2003). *Guidelines for medico-legal care for victims of sexual violence*. Geneva, Switzerland: Gender and Women's Health, Family and Community Health Injuries and Violence Prevention, Non-communicable Diseases and Mental Health
3. Ministry of Health. (2014). National Guidelines on Management of Sexual Violence (3rd Edition). Kenya
4. MOH (2014) National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya. Nairobi, Kenya: German development Cooperation

UNIT 3: PHYSICAL EXAMINATION AND PSYCHOLOGICAL ASSESSMENT

Purpose

Carry out a thorough physical examination and psychological assessment for children and adolescents

Expected Learning Outcomes

By the end of the unit participants should be able to;

1. Describe the procedure for general physical examination
2. Demonstrate ability to conduct physical examination
3. Describe the procedure for systemic examination with emphasis on genital and anal exam for girls and boys
4. Demonstrate ability to conduct and document psychological assessment
5. Document physical findings for purposes of clinical care and forensic examination.

Lesson Plan Guide:

Time: 3 Hours

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
45 mins	**General physical examination** - General physical examination	Perform general physical examination for children and adolescents	Brainstorming, experience sharing, illustrated lectures, Video, demonstration, role	National Guidelines, SOPs, LCD, Flip chart paper, marker pens,

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	- Head to toe inspection and examination - Documenting physical forensic findings	according to SOPs	plays, Check list, guided practice	ECSA,PRC form, Trainers guide, AIDSTAR-One
45 mins	**Systemic examination** - Full /thorough review of systems (injuries, site, depth,) - Thorough anal-genital examination for girls and boys - Document results of the examination	- Conduct a full systemic examination for children and adolescents according to SOPs - Document results of the examination according to SOPs	Diagrammatic illustration Illustrated Lectures, group discussions, case studies, check lists	National Guidelines, SOPs, LCD, Flip chart paper, marker pens, ECSA, AIDSTAR-One
45 mins	**Psychological assessment** - Assess for post traumatic reactions - Inappropriate sexual behaviors - Document	- Recognize psychological signs and symptoms - Conduct a psychological assessment	Diagrammatic illustration Illustrated Lectures, group discussions, case studies, check lists, role plays	National Guidelines, LCD, Flip chart paper, marker pens, ECSA, AIDSTAR-One

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	psychological findings			
45 mins	**Documentation of findings** - Document general physical findings - Document systemic findings including genital anal - Document findings in PRC form, SGBV register, Trauma counselling form - Document psychological findings	Competently document examination findings and observations on the forms	Practical filling of forms, samples of filled forms, scenarios, role plays	PRC form National Guidelines, LCD, Flip chart paper, marker pens, ECSA, AIDSTAR-One

Facilitator's notes

Physical examination of children and adolescents

- Å Before starting the physical examination, take time to explain all the procedures to the survivor and why they are necessary. Give the survivor a chance to ask any questions. Allow the survivor to have a family member or friend present throughout the examination, if s/he so wishes. Throughout the physical examination, inform the survivor what you plan to do next and ask for permission (informed consent).
- Å Both medical and forensic specimen should be collected during the course of the examination. Make sure that the survivor understands that s/he can stop the procedure at any stage if it is uncomfortable for her/him and give her/him ample opportunity to stop the examination, if necessary. Always address survivor's questions and concerns in a non-judgmental and empathic manner; use a calm tone of voice.
- Å Ensure a trained support person of same sex accompanies survivor throughout examination

Head to toe examination for children

- Å The physical examination of children can be conducted according to the procedures outlined for adults. Presence of mother, someone he/she trusts or a chaperone is important and should always be considered. When performing the head-to-toe examination of children, the following points are important:
- Å Record the height and weight of the child, as well as the head circumference in children younger than 3 years.
- Å In the mouth/pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum;

Record the child's Tanner stage of sexual development in either sex.

- Å Assess for any injury or disease process on all surfaces of the skin, including the soles of the feet, behind the ears, the axilla, the eyes, and oral cavity/mouth.

- Document the size, location, color, and type (abrasion, laceration, etc.) of any injuries or disease; photo-document if possible.
- Document any injuries or disease process noted.
- Once the full review of systems has occurred, the provider can focus on the anogenital examination of the child based on stage of development.

The Genito-Anal Examination for Girls

Remember that in most cases, a speculum exam is not indicated. It is only indicated when the child may have internal bleeding arising from a vaginal injury as a result of penetration.

- In this case, a speculum examination should be done under general anesthesia
- Examine the anus. Look for bruises, tears or discharge. Help the child lie on her back or on her side.
- The child may need to be referred to a higher level health facility for this procedure.
- For small girls, a pediatric speculum is recommended. Whenever possible do not conduct a speculum exam on girls who have not reached puberty. It might be very painful and cause additional trauma.

INDICATIONS FOR INTERNAL SPECULUM EXAM IN PREPUBESCENT GIRLS

- Bleeding from the vagina orifice
- Suggestion that a foreign body may be present in the vagina
- External genital injury requiring surgical repair

Examination Positions and Techniques

Supine frog-leg position

Child lying on exam table or lap of a caregiver with feet close together and knees loosely apart. Allows for good visualization of the labia, and ease of use with labial separation and traction techniques

Supine knee chest

Child lying on exam table or lap of a caregiver, with feet and knees together holding knees to chest (may need assistance). Allows for good visualization of the anus and surrounding tissues.

Prone knee-chest position

Child on exam table in a prone position. Head and torso are flush with the table, knees separated and down on exam table with buttocks raised. Allows for excellent visualization of the anus, surrounding tissues, and rectal cavity during dilation. With use of labial separation and traction, allows for assessment and confirmation of hymenal discrepancy visualized while child was in supine frog-leg.

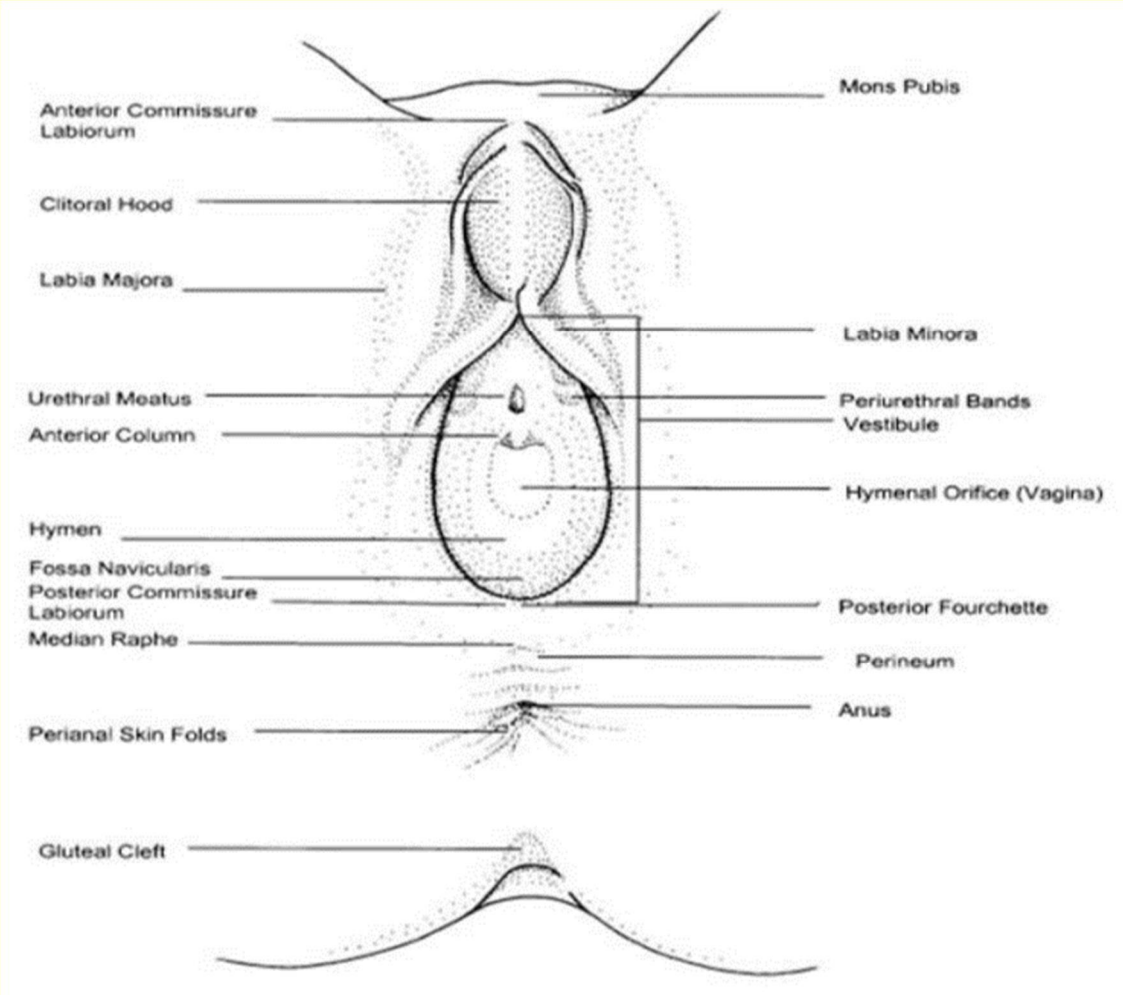
Labial separation With the child in a supine frog-leg position, the provider gently separates the child's labia with gloved hands allowing for visualization of the genital structures.

Labial traction With the child in a supine frog-leg position, the provider gently holds the child'slabia majora bilaterally between thumb and forefingers with gloved hands, pulling out toward the examiner and down toward the anus of the child. The examiner should pay close attention to the area of the posterior fourchette before, during,and after the exam as examiner-induced injury may occur.With the child in prone knee-chest position, the provider gently holds the child'slabia majora bilaterally between thumb and forefingers with gloved hands, pulling out toward the examiner and up toward the anus of the child. The examinershould pay close attention to the area of the posterior fourchette before, during,and after the exam as examiner-induced injury may occur.

In girls, assess the following external genital structures for injury or disease process: Mons pubis;Labia majora and minora ,Clitoral hood and clitoris,Urethra and periurethral tissues' Posterior fourchette,Fossa navicularis, Hymen,Vaginal vestibule

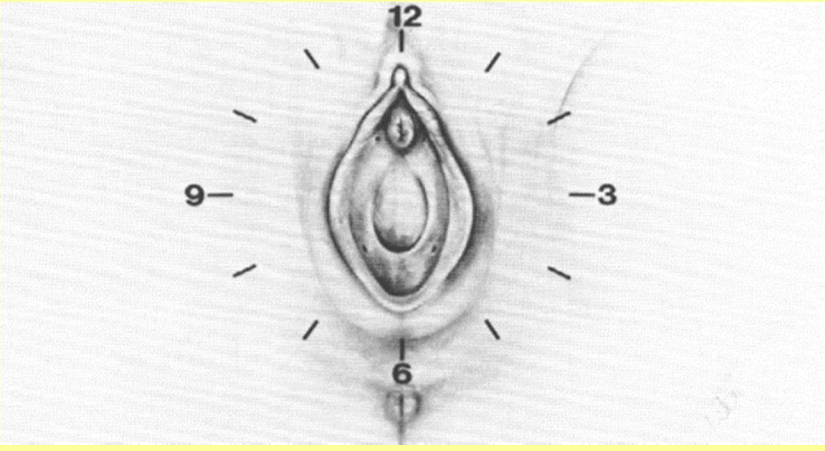
Perineum

Illustration of the Female Genital Anatomy



Documentation of the genital structure assessment and findings should be done using the clock face analogy

It is critical that the provider note the type of injury, size if possible, structure the injury is observed on, and color of the injury



EXAMINATION OF THE POSTPUBESCENT FEMALE

The adolescent girl who has reached puberty should receive a full pelvic examination in addition to the rest of the history and physical.

The lithotomy (laying on their back, knees bent, feet in stirrups, and thighs apart) position will also be used as performance of a speculum examination is standard practice

HYMENAL ASSESSMENT TECHNIQUES IN POSTPUBERTAL FEMALES

- Use of a moistened cotton-tippedswab to sweep around the hymenal edge to look for hidden tears/lacerations.
- Use of a small (8Fr) sterile Foley balloon catheter. The catheter is introduced through the hymenal opening into the vagina and the balloon is inflated to a degree that is tolerated (2-3 mL water in the balloon). The catheter is slowly and gently withdrawn until the balloon rests against the internal aspect of the hymen. The catheter is slowlyrotated around the clock face to allow full view of the hymenal edge

Genito-Anal Examination for Boys

- Check for injuries to the skin that connects the foreskin to the penis
- Check for discharge at the urethral meatus (tip of penis)
- In an older child, the foreskin should be gently pulled back to examine the penis. Do not force it since doing so can cause trauma, especially in a young child;
- Examine the anus. Look for bruises, tears, or discharge. Help the boy to lie on his back or on his side. The boy should not be placed on his knees as this may be the position in which he was violated.

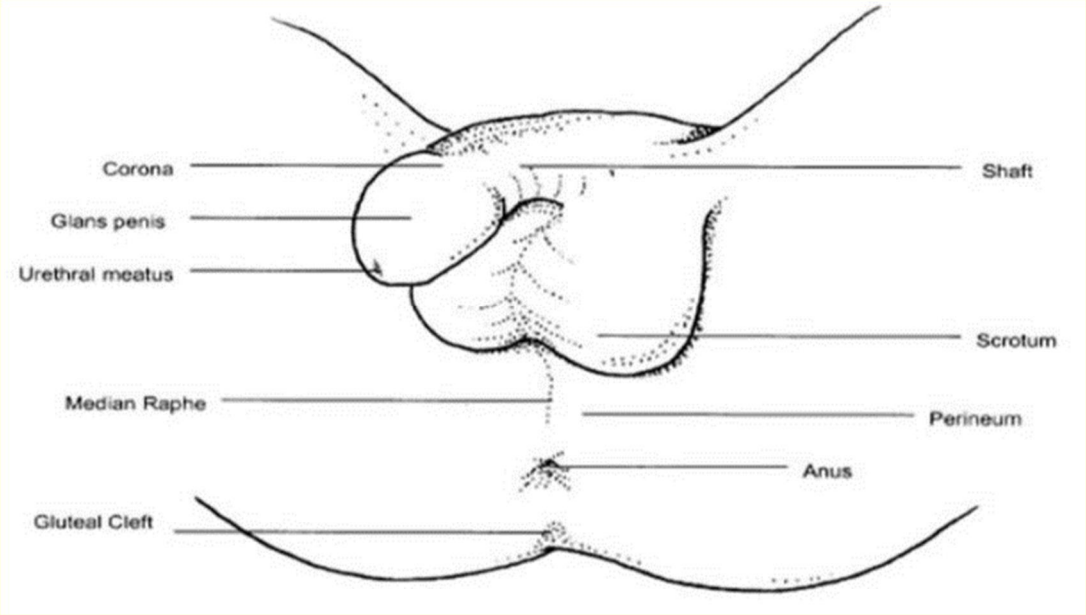
•Consider a digital rectal examination only if medically indicated, as the invasive examination may mimic the abuse.

EXAMINATION OF THE MALE

In boys, the genital examination should include the following structures and tissues, checking for signs of injury or disease process:

• Prepuce of the glans, Glans penis and frenulum, Urethral meatus, Penile shaft, Scrotum, Testes, Inguinal region, Perineum.

Illustration of the Male Genital Anatomy



ANAL EXAMINATION OF CHILDREN AND ADOLESCENTS

Examination of the anus in children is best approached utilizing either the supine or prone kneechest positions. In either position, apply gentle traction to part the buttock cheeks. During the course of an anal examination the following tissues and structures should be inspected, again looking specifically for signs of injury or disease process:

• Perianal area, paying particular attention to the perianal folds

• Anal verge/margin

• Anorectal canal

• Anus

• Gluteal cleft

A digital examination should only be used in cases where laxity of the sphincter is observed during the exam..Anoscopy is not routinely utilized, unless there is bleeding, obvious trauma, or question of lodged foreign body.

THE COLPOSCOPIC EXAMINATION

A colposcope is a noninvasive binocular field microscope with adjustable light illumination that creates a magnified image. It may also provide photographic capability for taking still or video images. When available, colposcopes are utilized for magnification of the anogenital area of children who have experienced sexual violence and exploitation to aid in identification of injury or disease process. It allows for a permanent record of the genital examination findings and in obtaining a second opinion. It also facilitates peer review, teaching, and training.

Because the cost of a colposcope is significant, many sites will not have them available. Providers can utilize any handheld magnifying device to aid in assessment of the genitalia.

PSYCHOLOGICAL ASSESSMENT

- Å The psychological assessment of the child should include the developmental stage of the child, and any signs of distress the child may be experiencing as a result of the sexual violence and exploitation they have experienced.
- Å Often they will have experienced psychological pressure, threats of physical violence, and coercion to participate in the sexual violence and exploitation.
- Å Children who experience sexual violence and exploitation need to feel they are in a safe environment, and the provider should assure that the child is not rushed or hurried through the examination.

Children who have experienced sexual violence and exploitation should be assessed for :

- Signs of depression
- Anxiety

Symptoms associated with posttraumatic stress disorder such as;

avoidance, numbing, hyperarousal

- Inappropriate sexual behavior
- Loss of social competence
- Cognitive impairment
- Substance abuse
- Alterations in body image
- Suicidal ideations

For prepubescent children, the examination should focus on the external genitalia. Generally speaking, no speculum or digital examination11 of prepubescent girls should occur.

Documentation

Summary of findings to be documented after examination of a survivor of sexual violence:

General examination

• Document the state of clothes- the colour, whether stained or torn, where they were taken to

• Document vital signs of the survivor

Mental assessment

Document as per the psychological assessment form.

Systemic examination

Document details of the:

• ***Central nervous system***- level of consciousness, affect

• ***Musculo-skeletal system***- physical disabilities, posture control and gait, swellings, bruises, lacerations, dislocations, bite marks, scratches on the body of survivor from head to toe.

• ***Perineum***- The perineum consists of the clitoris, labia majora and minora, vagina, mons pubis, introitus, fossa navicularis, vestibule, hymen, penis, prepuce, scrotum, urethra, anus, gluteal region, inner medial thighs.

- In the above areas, document:
- Any tenderness, bruises, abrasions, cuts, teeth -marks, scratch marks bleeding, discharge, old scars (question their source if any)
- Details of the anus- shape, dilatation (sphincter muscle tone), fissures, faecal matter on perianal skin, bleeding from rectal tears.
- Details of the hymen- shape, position, colour, and type e.g. Cribriform, septal, cresent shaped, carunculae.
- Position and size of tears e.g. At 3 o'clock 1 cm etc

References and Recommended Reading

1. AIDSTAR-One. (Feb. 2012) The Clinical management of Children and Adolescents who have Experienced Sexual Violence; *Technical Considerations for PEPFAR Programs*.
2. World Health Organization. (2003). *Guidelines for medico-legal care for victims of sexual violence*. Geneva, Switzerland: Gender and Women's Health, Family and Community Health Injuries and Violence Prevention, Non-communicable Diseases and Mental Health
3. Ministry of Health. (2014). National Guidelines on Management of Sexual Violence (3rd Edition). Kenya
4. MOH (2014) National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya. Nairobi, Kenya: German development Cooperation

UNIT 4: INVESTIGATION AND FORENSIC MANAGEMENT

Purpose:

To demonstrate competency in collecting and handling specimen for both clinical and forensic purposes

Expected Learning Outcomes

By the end of the unit participants should be able to;

1. Demonstrate skills to collect evidence for clinical management of children and adolescents
2. Collect, handle, preserve and transfer of forensic evidence for legal purposes
3. Document for management and legal purposes
4. Demonstrate ability to interpret injuries and link with observations made and obtained history

Lesson Plan Guide:

Time: 1 Hour

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
10min	**Collection of evidence for Clinical management** - Outline	- Identify the range of	Diagrammatic illustration	National

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	investigations for clinical management - Discuss importance of investigations for clinical management	investigations that are typically of interest in SV - Practice the skills in collection of evidence	Illustrated Lectures, group discussions, case studies, check lists	Guidelines, SOPs, LCD, Flip chart paper, marker pens, ECSA,PRC form, Trainers guide, AIDSTAR-One
30min	Collecting ,handling, preserving evidence for legal purposes	Demonstrate ability to collect, handle and preserve forensic evidence	Diagrammatic illustration Illustrated Lectures, group discussions, case studies, check lists	National Guidelines, SOPs, LCD, Flip chart paper, marker pens, AIDSTAR-One, WHO guidelines
20 min	**Documentation for management and legal purposes** - Documenting investigations and forensic specimens by type -Documentation of investigations results in PRC form and SGBV register	Competently document findings for management and legal purposes	Diagrammatic illustration Illustrated Lectures, group discussions, case studies, check lists	National Guidelines, SOPs, LCD, Flip chart paper, marker pens, PRC forms, AIDSTAR-One

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	Interpretation of injuries	Interpret injuries and link with observations made and obtained history	Mini Lectures, Video, case scenarios, Group Discussion	AIDSTAR-One,WHO guidelines for medico-legal care

Facilitator's notes

The purpose of forensic specimens

The objective of forensic evidence is to prove or exclude a physical connection between individuals and objects or places. Such evidence comprises a wide variety of substances or objects, the analysis of which requires specific, often specialized scientific skills.

The close encounter of assailant, victim and crime scene may result in an interchange of traces of evidence (Locard's principle). Biological traces (i.e. hair, blood, semen, skin fragments) may be found on both the victim and assailant; for instance, the victim's blood could get onto the assailant's clothes. Fragments from the scene (e.g. mud, vegetation) may link a victim and assailant to a particular location, or they may each have left traces of clothing or biological traces at the scene.

On the basis of the facts available and information provided by the patient and investigators, the health worker must decide which specimens to collect from the individuals involved. When faced with such decisions, it is important to be mindful of what purpose the specimen will serve, what link is potentially going to be established and whether such a link may assist the investigation of

the case**.**

Specimen collection process

Specimen collection should be done during examination.

Basic investigations to know the general condition of the survivor will include urine specimen and blood tests as indicated below.

FORENSIC SPECIMEN EVIDENCE COLLECTION			
SITE	**MATERIAL**	**EQUIPMENT**	**SAMPLING INSTRUCTIONS**
Anus (rectum)	Semen	Cotton swabs and microscope slides	Use swab and slides to collect and plate material; lubricate instruments with water, not lubricant.
	Lubricant	Cotton swab	Dry swab after collection.
Blood	Drugs	Appropriate tube	Collect 10 ml of venous blood.
	DNA (victim	Appropriate tube	Collect 10 ml of blood.
Clothing	Adherent foreign(e.g. semen, blood, hair, fibres)	Paper bags	Clothing should be placed in a paper bag(s). Collect paper sheet or drop cloth. Wet items should be bagged separately.
Genitalia	Semen	Cotton swabs and microscope slide	Use separate swabs and slides to collect and plate material collected from the external genitalia, vaginal vault and cervix; lubricate speculum with water not lubricant or collect a blind vaginal swab
Hair	Comparison to hair found at scene	Sterile container	Cut approximately 20 hairs and place hair in sterile container.
Mouth	Semen	Cotton swabs, sterile container(for oral washings)	Swab multiple sites in mouth with one or more swabs. To obtain a sample of oral washings, rinse mouth with or dental flossing 10 ml water and collect in sterile container.
	DNA (victim)	Cotton swab	
Nails	Skin, blood ,fibres, etc. (from assailant)	Sterile toothpick or similar or nail scissors/clippers	Use the toothpick to collect material from under the nails or the nail(s) can be cut and the clippings collected in a sterile container
Sanitary pads/ tampons	Foreign material(e.g. semen, blood, hair)	Sterile container	Collect if used during or after vaginal or oral penetration.
Skin	Semen	Cotton swab	Swab sites where semen may be present. 1
	Saliva (e.g. at sites of kissing, biting or licking),blood	Cotton swab	Dry swab after collection.
	Foreign material(e.g. vegetation, matted hair or foreign hairs)	Swab or tweezers	Place material in sterile container (e.g. envelope, bottle).
Urine.	Drugs	Sterile container	Collect 100 ml of urine

Urine

- Urinalysis – microscopy
- Pregnancy test
- Spermatozoa

Blood

- HIV Test
- Haemoglobin level
- Liver Function Tests
- VDRL /HBSAg, Hep C,

The health professional should collect the specimen, preserve it for appropriate storage and hand it over to the police for further investigations and processing in the courts.

Recording and classifying injuries

Clinicians and pathologists are frequently required to respond to questions about injuries from investigators, lawyers or the courts. The sorts of things that investigating teams want to know about are:

— the age of an injury;

— how (i.e. the mechanism by which) the injury was produced;

— the amount of force required to produce the injury;

— the circumstances in which the injury was sustained;

— the consequences of the injury.

Injury interpretation is, however, both a complex and challenging matter. Without accurate documentation and expert interpretation of injuries, any conclusions drawn about how injuries occurred might be seriously flawed. This will have profound consequences for both the victim and the accused.

DESCRIBING FEATURES OF PHYSICAL INJURIES

Classification/type

Use accepted terminology whenever possible; such as, abrasion, bruise, laceration, incised wound

Site

Record the location of the wound/injury

Size

Measure the wound (using a ruler or other standardized method such as a coin)

Shape

Describe the shape of the wound(s): linear, curved, irregular

Surrounds

Note the condition of nearby tissues: bruised, swollen, tender

Color

Observe any changes in color: redness, bruising, pallor

Contents

Note the presence of foreign material in the wound: dirt, debris, glass

Age

Note any healing injuries, such as cuts that are scabbed; use great caution in this area, do NOT date or attempt to date bruising

Borders

Characterize wound margins: ragged, smooth

Depth

Give an estimate of the depth of the wounds, if present

References and Recommended Reading

1. AIDSTAR-One. (Feb. 2012) The Clinical management of Children and Adolescents who have Experienced Sexual Violence; *Technical Considerations for PEPFAR Programs*.
2. World Health Organization. (2003). *Guidelines for medico-legal care for victims of sexual violence*. Geneva, Switzerland: Gender and Women's Health, Family and Community Health Injuries and Violence Prevention, Non-communicable Diseases and Mental Health
3. Ministry of Health. (2014). National Guidelines on Management of Sexual Violence (3rd Edition). Kenya
4. MOH (2014) National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya. Nairobi, Kenya: German development Cooperation

UNIT 5: TREATMENT AND COUNSELLING

Purpose

Apply appropriate treatment protocols for management of children and adolescents survivors of SV.

Expected Learning Outcomes

By the end of the unit participants should be able to;

1. Demonstrate ability to identify and manage life threatening injuries Pregnancy prevention and management
2. Provide ART prophylaxis
3. STIs prevention and management
4. Hepatitis B prevention
5. Provide basic psychosocial support

Lesson Plan Guide:

Time: 2 Hours

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
20 mins	**Management of life threatening and other injuries** - stabilize patients with life threatening	• Demonstrate ability to manage life	Diagrammatic illustration Illustrated Lectures, group discussions, case studies,	National Guidelines, SOPs, LCD, Flip chart

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	injuries - Treatment of life threatening injuries and other physical injuries - Immunization	threatening and other injuries utilizing standard protocol • Describe management of different injuries	check lists	paper, marker pens, ECSA,PRC form, Trainers guide, AIDSTAR ONE
10 mins	**Pregnancy Prevention and Management** - Timing - Regimen	• Describe protocols for preventing unwanted pregnancy	Diagrammatic illustration Illustrated Lectures, group discussions, case studies, check lists	National Guidelines, SOPs, LCD, Flip chart paper, marker pens, PRC forms, FP guidelines AIDSTAR-one
10 mins	**Prevention of HIV** - Mode of transmission - HTC - PEP - Adherence	• Apply relevant protocols for HIV testing and administration of PEP	Illustrated lectures, brainstorming	National Guidelines, SOPs, LCD, Flip chart paper, marker pens, PRC forms, Algorithms AIDSTAR-one
10 mins	**STIs prophylaxis and treatment** - Diagnosis - Types of STIs & symptoms - Treatment	• Apply knowledge for STIs prophylaxis using the standard protocols to manage children and	Illustrated Lectures, group discussions,	National Guidelines, SOPs, LCD, Flip chart paper, marker pens, PRC forms,

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	- Regimen	adolescents		Algorithms AIDSTAR-one
10 mins	**Hepatitis B prevention** - History of Hep B vaccination	• Apply relevant protocols for Hep B prevention for children and adolescents	Illustrated Lectures, group discussions,	National Guidelines, SOPs, LCD, Flip chart paper, marker pens, PRC forms, Algorithms AIDSTAR-one
45 min	Psychosocial Support	Apply the basics of counselling children	Brainstorming, mini-lectures, role plays	Trainers manual, GVRC training manual
15 mins	**Documentation of treatment on PRC form ,SGBV register and trauma counseling form** - Document all the treatment offered in the PRC form in PRC form, registers etc.	• Competently document treatment on PRC form	Diagrammatic illustration Illustrated Lectures, group discussions, case studies, check lists	National Guidelines, SOPs, LCD, Flip chart paper, marker pens, PRC forms, AIDSTAR-One

Facilitator's notes

Management of injuries in sexual violence

Management of any life threatening injuries takes precedence over all other aspects of post-rape care. Minor cuts and abrasions should not delay the delivery of other more time dependent treatments

Clean abrasions and superficial lacerations with antiseptic and either dress or paint with tincture of iodine, including minor injuries to the vulva and perineum.

- If stitching is required, stitch under local anesthesia. If the survivor's level of anxiety does not permit, consider sedation or general anesthesia.
- High vaginal vault, anal and oral tears and 3rd/4th degree perineal injuries should be assessed under general anesthesia by a gynecologist or other qualified personnel and repaired accordingly.
- In cases of confirmed or suspected perforation, laparatomy should be performed and any intra-abdominal injuries repaired in consultation with a general surgeon
- Provide analgesics to relieve the survivor of physical pain. Where any physical injuries result in breach of the skin and mucous membranes, immunize with 0.5mls of tetanus toxoid.
- In a previously unvaccinated child, it may be necessary to administer anti tetanus serum and start a course of tetanus toxoid vaccine . For children younger than 7 years old, Diptheria, Tetanus and pertussis (DPT) or Diptheria and Tetanus (DT) is

preferred to tetanus toxoid alone. For children 7 years and older, Td is preferred to tetanus toxoid alone**.**

Prevention of pregnancy:

Pregnancy as a consequence of sexual violence and exploitation should be a concern for any female child (Tanner stage III) irrespective of menarche.

Even a single exposure can result in pregnancy. Depending on the legality, as well as national protocols that guide the provision to minors, EC should be offered up to five days (120 hours) after the sexual violence and exploitation.

Recommended dosage is 1.5 mg of progestin-only contraceptive in a single dose. The efficacy of this regimen is best if used within 72hours; however, it can be administered up to 120 hours. If the assault occurred outside the 120-hour window for EC, then pregnancy testing can be offered.

An alternative EC regimen that is effective up to 120 hours post-exposure is ulipristal acetate, 30 mg orally as a one-time dosage. It has been found to be more effective than levonorgestrel, especially up to the 120 hour limits (Glasier et al. 2010).

- There are limited side effects to EC. Nausea and vomiting may occur, but is more likely to been countered in the estrogen-based medications no longer recommended. Other side effects may include breast tenderness, spotting or bleeding, and menstrual irregularities. Antiemetic medications can be offered if the patient is experiencing nausea prior to taking EC. Children who are pregnant at the time of the examination should be offered information on any options available to her.

Prevention of HIV:

The risk for HIV can be reduced if a child is evaluated for and offered

HIV post-exposure prophylaxis within 72 hours of the assault.

Children might be at higher risk for HIV transmission than adults because the sexual violence and exploitation of children is frequently associated with multiple episodes of violence and might result in mucosal trauma.
Specific circumstances of sexual violence and exploitation (e.g., bleeding, which often accompanies trauma) might increase risk for HIV transmission in cases involving vaginal,anal, or oral penetration. Site of exposure to ejaculate, viral load in ejaculate, and the presence of anSTI or genital lesions in the assailant or child who has experienced sexual violence and exploitation also might increase the risk for HIV infection**.**

HIV counseling and testing (HCT) should always be offered as part of the PEP service package based on informed consent with standard pre-test and post-test counseling according to national or local protocols. HIV testing should not be mandatory or prerequisite for providing PEP, and the results should be treated in the strictest confidence.
If HTC is not available at the service site and the child falls within the guidelines for PEP, then the medications should be started as soon as possible. It is not recommended that children be referred to programs for preventing mother-to-child transmission, as the drug regimens prescribed in such circumstances are inappropriate for PEP.
Whenever possible, confidential HCT should be done onsite.In the absence of this option, the child should be referred to an HCT center. Regardless of where the child is tested, appropriate counseling services should be made available before and after HIV testing.

The child, caregiver, and health worker must evaluate the risks and benefits of initiating or refraining from PEP treatment and decide together the best option for the child. If PEP is offered, the following information should be discussed with the child and caregiver:

• The unproven benefits of antiretrovirals

• The known toxicities of antiretrovirals

• The importance of close follow-up

• The benefit of adherence to recommended dosing

• The necessity of early initiation of PEP to optimize potential benefits (i.e., as soon as possible after and up to 72 hours after the assault)

Providers should emphasize that PEP appears to be well-tolerated in children and that severe adverse effects are rare**.**

Recommended PEP Regimens for Children and adolescents

For children and adolescents, the recommended triple therapy regimen is as follows:

ABC + 3TC +LPV/r

Children's doses must be given according to weight as per the National guidelines. Both syrups and tablets can be used.

The sooner PEP is initiated after the exposure, the higher the likelihood that it will prevent HIV transmission,if HIV exposure occurred. However, distress after an assault also might prevent the child from accurately weighing exposure risks and benefits of PEP and from making an informed decision to start such therapy. If prescribed, PEP should be initiated within 72 hours of the sexual violence and exploitation and be given for 28 days. Patient liver enzyme levels and renal function should be measured and a complete blood count made prior to the commencement of PEP (to establish baseline values) and then monitored at regular intervals until the treatment has been completed.

If the initial test results for HIV were negative, children should have the test repeated at 6, 12, and 24 weeks after the assault. If the initial testing was not accepted at the time of the examination, the child should still be told that they can return for testing. If available, a professional specializing in HIV infection in children should be consulted prior to prescribing PEP.

Side Effects of PEP

Patients taking PEP should be forewarned about the possibility of experiencing the side-effects below, and prepared on how to deal with them should they occur. They should for instance be informed that they can reduce the intensity by taking the pills with food. Side-effects usually diminish with time and do not cause any long-term damage. Extreme side effects are rare due to the short duration of PEP treatment.

Drug	Possible side effects
Tenofovir	Renal toxicity and bone mineral loss.
Zidovudine	Anaemia, gastrointestinal side-effects, and proximal muscle weakness.
Abacavir	Skin rash, cough, fever, headache, asthenia, diarrhoea
Lamivudine	gastrointestinal side-effects, anaemia,
Lopinavir/ ritonavir	gastrointestinal side-effects

THE OPTIONS FOR DISPENSING PEP AT THE INITIAL CONSULTATION ARE AS FOLLOWS:

• An initial supply of medicine to last 1–7 days (starter packs)

•Medicine provided every week or two weeks to encourage follow-up and to minimize possible waste of medicine(incremental dosing)

• The full 28-day course of medicine supplied at the initial visit (maximizing the likelihood of completion if follow-up is aconcern

STI prevention and Managemnt

In prepubertal children a "dirty urine" (or random voided urine specimen) or nucleic acid amplification test (NAAT) is superior to genital swabs. The NAAT is also appropriate for the adolescent population. In the absence of NAAT, genital swabs in prepubescent children should be taken from the vulva and beside the vaginal orifice.

Cervical specimens are only required in adolescents (i.e., those at Tanner stage II of puberty or later), as adolescents may have asymptomatic infections. Presumptive treatment for infection should be offered in children who have experienced sexual

violence and exploitation according to local policies. Children and adolescents who test positive for STIs should be treated according to national protocols. Specimens may be required to test for STIs and pregnancy (in the case of the postpubertal female). If a provider tests for STIs, testing for HIV should also be offered.

The diagnosis of an STI in a prepubertal child or adolescent who has not become sexually active may be evidence that the child has experienced sexual violence and exploitation. Which diagnostic testing is necessary should be determined on a case-by-case basis. Which tests are performed and the results of any testing should be documented in the medical record. The following diagnostic tests may be necessary to complete in children:

Å NAAT urine test for Chlamydia trachomatis and Neisseria gonorrhea. This specimen can be obtained as a "dirty" (a random voided, non–clean catch specimen).

Å Trichomoniasis testing of a portion of the "dirty" urine specimen.

Å Human papilloma virus (HPV) testing using swabs of the vulva, perineum, and surrounding genital tissues. This may be done with or without the presence of warts.

- Herpes simplex virus (HSV) cultures may be obtained by unroofing a vesicle and sending the fluid for culture. Autoinoculation may occur, and may not be diagnostic for sexual abuse. Viral culture can distinguish between type 1 and type 2.

- Serologic baseline HIV testing should be offered at the time of the exam, and done if consent is given.

Å Vertical transmission (acquired intrauterine) of HIV and other STIs can occur. Transmission can also occur from the birth process through cervical secretions of the mother (gonorrhea,chlamydia, HPV, HSV).

Å Implications of commonly encountered STIs for diagnosis and reporting of sexual violence and exploitation among infants and prepubertal children.

When using diagnostic testing for STIs in children, it is important to know the timing of the sexual violence and exploitation, as STI cultures are likely to be negative, unless the child has a preexisting infection.Follow-up testing may be necessary in acute sexual violence and exploitation cases to repeat testing done at the initial examination.

Childrenôs prophylactic treatment for STIôs					
Children	Product	Presen-tation	Strength	Dosage	Duration
5-12kg	Cefixime	Powder for sus-pension	100mg/5ml	8mg/kg	stat
	Azithromycin		200mg/5ml	20mg/kg	
12-25kg	Cefixime	Tablet or capsule	200mg	200mg	
	Azithromycin		250mg	500mg	
25-45kg	Cefixime		200mg	400mg	
	Azithromycin		250mg	2g	

Alternative treatment

Amoxicillin 15mg/ kg TDS for 7 days PLUS Erythromycin 10mg/kg QID for 7 days

Childrenôs prophylactic treatment for trichomoniasis					
Children	Product	Presen-tation	Strength	Dosage	Duration
<45kg	Tinidazole	Tablet +/-pow-der for suspen-sion	500mg	50mg/kg (max 2g)	stat
	Metronidazole		250mg or 500mg or 125mg/ml	30mg/kg/ day in 3 dosages	7 days

HEPATITIS B VIRUS (HBV)

- There is no information on the incidence of HBV following sexual violence and
- exploitation. However, HBV is present in semen and vaginal fluid and is sexually transmitted.
- If possible, the hepatitis B vaccination should be administered to
- unvaccinated children who have experienced sexual violence and exploitation within 6 weeks of the last incident.

- Children who have experienced sexual violence and exploitation are at increased risk of contracting HBV if they have not been immunized against it. If there is vaccine available, and the child has not been immunized, they should be treated with the appropriate type of vaccine and dosage.
- The first dose should be given at the time of the examination, as a component of the treatment.
- Once the vaccine is initiated, then the child (or caregiver as appropriate) should be instructed to complete the series of three doses and encouraged to have a booster after one year.

PSYCHOSOCIAL SUPPORT

Counselling Children and Adolescents

Children require action oriented approaches to facilitate the counselling process Because some children may have no experience of an adult listening to them and Therefore may react with suspicion or resistance to the counsellor.

Communicating about Sensitive Issues

The dynamics of child sexual abuse differ from those of adult sexual abuse in that; Children rarely disclose sexual abuse immediately after the event, due to the fact that most are threatened, intimidated and confused, Disclosure tends to be a process rather than a single episode and is often initiated following a physical complaint or a change in behaviour. Helpers should therefore:

☐ Develop a sense of trust, safety in the therapeutic setting a component of a working alliance- cooperation.

☐ Understand the child's perception of the abuse. Let them be aware of what has happened and the impact.

☐ Show sensitivity in handling of disclosure of diagnosis. Secrecy brings in dilemma for the child. Remember children want to remain loyal. If there is a lot of fear and/or pain, give reassurance.

☐ Establish a safe environment - this refers to a sense of trust. Learn to tolerate delays and frustration.

☐ Let the child know that you have a positive alliance with the positive care giver- this gives a sense of safety.

☐ Create rapport, let the child go at her/his own pace and listen carefully.

☐ The Helper should be aware of the developmental stage of the child.

The Language of Children

To communicate to children you must be able to speak and understand their language. Children speak 3 languages:

- The language of the body
- The language of play
- Spoken language

Along with these languages, there are four indirect methods that can help children express their feelings:

- Drawing
- Story-telling
- Drama
- Play

Drawing

Drawing can be a powerful activity for opening hidden cupboards in a child's life. Drawing enables children to communicate their emotional state without having to put it into words. Most children enjoying drawing and it is a useful practical tool for counselling. After a child has drawn something gently follow up by asking the child to describe what is happening in their drawing.

Example:

Jane drew a picture of a man who used to do "bad things" to her. When the counsellor asked her about her drawing, she told how she used to be defiled by an uncle who ended up infecting her with HIV.

Storytelling

Children usually do not like to answer lots of direct questions or listen to long lectures. When they are finding it difficult to talk about painful issues, asking them to tell a story may help them express themselves. A story can also serve as a useful tool for problem solving.

Example:

A counsellor could ask children to tell a story about their school, home, friends or parents. They could be asked to tell a story about things that bother them in their lives.

Drama

Drama or role-play is an excellent way for children to raise issues they want to communicate with others but find it difficult to discuss directly.

Example:

Children could be asked to act out how they spend their time at home, or to act out their relationships with parents or siblings. Children who are abused at home could demonstrate their situation through drama.

Play

Adults often think play serves no serious purpose. But play is an important way that children express their feelings about events and make sense of their world. When children play, much of their activity involves imitation or acting out things that concern them in their lives. By watching children play, adults can begin to understand what emotions they are experiencing.

Example:

Four HIV positive children were told to go play before going to see the doctor. They started acting out a situation in which a person had died in the home. One of the children acted as a dead body and 2 other children were crying. One child cried, "Who

have you left me with?" the oldest child was trying to move the body and telling the others to be strong: "It is God's decision." The counsellor watched what was happening and then asked for an explanation. The children explained why they were acting out this situation.

When using play as a way to understand what children are feeling, always observe what the children are doing and follow up afterwards. Do not try to direct their playing.

In conclusion, innovative, creative and child-friendly methods of communicating are very important to help children feel involved and express their feelings and emotions. With older children you can engage in non-play therapeutic counselling.

Knowledge needed to communicate with Children

- Knowing the developmental stage of a child
- Knowing how to assess the child's understanding
- Knowing what the likely reactions and questions are and how to handle them
- Knowing what difficult questions children may ask and how to handle them
- Knowing how to handle your feelings and reactions during the process of counselling.

Adolescents

Understand the developmental stage of the adolescent

Understand their language

Be very patient with them

Be up-to –date on their lifestyle and current activities

Be youth friendly

Be available

Accept the youths the way they are

Non-judgemental

Be able to impact or strengthen life and social skills

Tone of Voice

When dealing with children it is important to pay attention to your tone of voice.

- The tone indicates your thoughts and attitudes.
- If you speak too quietly or hesitantly the caller may find it hard to have confidence in you as a helper.
- It would be counterproductive to be forceful.
- Try to talk clearly at a fairly steady level rather than mumble or stumble
- Avoid sounding rushed or excited.
- Try to mirror the tone of the child to help them hear the emotion conveyed

Do's for communicating with children:

- Do take a "one down position," which means showing the child that he/she knows more about certain things than an adult?
- Use minimal encouragers. This means using brief words and gestures to encourage the child to go on talking.
- Be as fully present as possible. "The whole of you should be there."
- Externalizing. This involves separating the problem from the child e.g. not labelling a child a truant, bed wetter or orphan.
- Call children by their names not by colour, height, size or place of origin and most importantly not by labelling them in relation to bad behaviour.
- Reframe (or re-label). Reframing involves restating the situation the child has described in a more positive way. For example, if a child says that a playmate has told him that his mother has AIDS because she is a sinner, the counsellor can explain that AIDS affects all kinds of people and that AIDS is not a sin.

- Be patient. There is no need to rush; children will tell or show you what they are ready to show or tell you. Even if they are quiet, there are thoughts going through their head. Try to move at their pace.
- Show interest in the child. Children will feel valued if you show interest in their lives.
- Be open and honest with facts. If you give information be accurate and precise.
- Maintain a non-judgmental attitude. Counsellors are not trained to be judges of children but to offer badly needed emotional support.
- Be empathetic. Put yourself in the shoes of the children and feel with them.
- Maintain confidentiality and privacy. Don't share sensitive information except when necessary to help the child. Handle it within your community.
- Maintain a calm and approachable attitude
- Maintain a caring attitude.
- Show acceptance of the child and what he/she is telling you.
- Factor in differing perceptions, especially, if the child and counsellor have different backgrounds, knowledge and experience.
- Use the local language which the children and their families can understand.
- Understand and maintain control of your own emotions. Refer the child to someone else if you feel your emotional involvement is endangering your ability to help him/her.
- Network with other counsellors for personal support and guidance.
- Know your limits and strengths.
- Try to develop good listening skills and attending behaviour
- Develop good question and answer techniques. Use open-ended questions. Make sure you understand a child's question before answering.
- Summarize and clarify what a child has told you.
- Explain what you will do with the information

- Take children seriously
- Treat children as equals
- Be nice and model good kind behaviours.
- Say "yes" a lot. In fact, for each "no" find two or three things that are "yes".
- Word things in positive terms
- Tell them their feelings are okay.
- Set boundaries that keep them safe.
- Allow the feelings but redirect any dangerous, destructive, or abusive actions.
- Be honest, but keep adult information with adults.
- Present options when they seek your counsel (limit options for younger children).
- When giving choices try to give two choices that will both accomplish what needs to be done. (Peter, you can do your homework and then watch your show or do your homework and then go outside, which would you like better)
- Delight in their discoveries, share their excitement.
- Discuss their dreams and nightmares.
- Laugh at their jokes.
- Be relaxed, calm, loving, and nurturing as much as possible.
- Answer their questions, or even better, help them answer them.
- Use your ears more than your mouth.
- Apologize when you've done something wrong.
- Keep the promises you make.
- Thank them for calling
- Refer to professional help when they need it.

Don'ts of communicating with children:

- Don't have a judgmental attitude.
- Don't speak in a commanding manner.

- Don't compare children.
- Don't make empty promises.
- Don't talk too much.
- Don't interrupt when a child is talking.
- Don't blame the child as he/she tries to express his/her feelings.
- Don't look down upon the child.
- Don't ignore the child.
- Don't allow emotions like anger, jealousy and fear to develop.
- Don't form a sexual relationship with the child you are helping.
- Don't use negative body language such as negative facial expressions or sitting postures.
- Don't evaluate the situation too quickly.
- Don't give the child too much information all at once.
- Don't patronize the interview process
- Don't sit or stand at higher level than children
- Don't put words in the child's mouth or let other adults do so
- Don't interrupt the child
- Don't talk too much about yourself (unless asked)
- Don't continue with the interview if a child gets upset (stop and take break, ask if it's ok to go on).

Documentation of treatment on PRC form and SGBV register

The child or adolescent who reports to the clinic for care should have a written record of the encounter. This record should include a medical forensic report, diagrams or body maps of any findings, and, if available, photographs. All aspects of the care should be documented including consent forms, the medical forensic history, findings from the physical assessment, evidence collected, any testing or treatment rendered,

photographic images obtained during the examination,and any follow-up care and referrals given.

If the health care provider is called to testify in any criminal justice proceedings, they may use this report to recall the patient encounter.

The written record should accurately reflect the child's demeanor, any statements made by the child during the course of treatment, and any caretaker history of events. All information documented should be legible and accurate. Any statements made by the child should be put in quotations, verbatim, rather than making an interpretation of what is said. It is generally preferable to use a standard form to document the examination, for convenience and reliability.

All injuries should be documented clearly, using standard terminology and descriptive language. At a minimum all injury or wound descriptions should include the type of injury (bruise, laceration,etc.), the size of the injury, the color, and the location.

Describe the injury without making speculation on the cause of the injury; however, if the child details where the injury is from, it is appropriate to document their words, in quotations. Make note of any samples collected from injuries. Wounds should be photographed prior to interventions such as cleaning or suturing.

When care is provided to a child who has experienced sexual violence and exploitation, the possibility exists that the health care provider may need to produce documentation and testimony regarding that care.

References and Recommended Reading

1. AIDSTAR-One. (Feb. 2012) The Clinical management of Children and Adolescents who have Experienced Sexual Violence; *Technical Considerations for PEPFAR Programs*.
2. World Health Organization. (2003). *Guidelines for medico-legal care for victims of sexual violence*. Geneva, Switzerland: Gender and Women's Health, Family and Community Health Injuries and Violence Prevention, Non-communicable Diseases and Mental Health
3. Ministry of Health. (2014). National Guidelines on Management of Sexual Violence (3rd Edition). Kenya
4. MOH (2014) National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya. Nairobi, Kenya: German development Cooperation

UNIT 6: FOLLOW UP CARE AND REFERRAL

Purpose:

Effectively utilize existing referral mechanisms for successful follow up care and integration/rehabilitation of the survivor back into the community

Expected Learning Outcomes

By the end of the unit participants should be able to;

1. Identify referral needs
2. Refer for specialized treatment
3. Identify appropriate service providers for holistic care

4. Describe referral and networking mechanism for SV survivors
5. Monitor adherence to treatment and psychosocial support
6. Monitor psychological state of the survivor
7. Include the role of the healthcare provider in follow up care
8. Inform survivors about key actors to be involved in their management

Lesson Plan Guide:

Time: 30 min

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
5min	**Referrals** **-**Definition of effective referral - Importance of referral systems - Referral components - Referral mechanisms	- Identify the need for referral and appropriately refer - Correctly and completely fill referral forms	Illustrated Lecture	National Guidelines, SOPs, LCD, Flip chart paper, marker pens, ECSA,PRC form, Trainers guide, AIDSTAR-one' Referral form ,Kenya Health sector referral guidelines
15 min	**Follow up** -Role of community in referral systems -Resources required for referral -Follow up care	Employ effective follow up care and management	Brainstorming, Discussions	National Guidelines, SOPs, LCD, Flip chart paper, marker pens, PRC forms,

Time	Content	Training Objectives	Training methodology and learning activities	Resource Materials
	-Counselling and social support - Role of HCPs in follow up care			Algorithms AIDSTAR-one
10 min	- Key actors	Identify available key actors	Discussions, Brainstorming	AIDSTAR-one

Facilitator's notes

Definition of Effective Referral

In the context of sexual violence service provision, referral is the process by which client's immediate needs for care, prevention, and supportive services are assessed, prioritized and the client is provided with assistance in accessing the necessary services. Referral also includes reasonable follow-up efforts necessary to facilitate initial contact with prevention, care, and psychosocial services and to solicit clients' feedback on satisfaction with services.

Importance of Referral Systems

Referral helps provide better services. When a referral is appropriately and properly executed it can aid recovery, psychological and emotional support, diagnosis, treatment, and specialized care**.**

Referral Components

- Problem identification
- Problem assessment

- Problem diagnosis
- Referral counselling
- Communication
- Transfer
- Facility feedback
- Community feedback

The Community in the Referral System

- Community involvement in planning, designing, developing and supporting the referral system affects its population.
- Community education gives information to understand and appreciate referral systems and participate in the referral
- Community participation may provide finances and transport, give feedback, accept clients back into the community and promote referral.

Follow-up care

Medical review

Follow-up visits are recommended at 2 weeks, 3 months and 6 months post Assault**.**

The 2-week follow-up visit

As part of the 2-week post-assault visit, the following routine tasks and checks should be performed:

● Examine any injuries for proper healing.

● Photograph injuries if indicated (i.e. to document healing, comparisons in court).

● Check that the patient has completed the course of any medications given for STIs.

● Obtain cultures and draw blood to assess STI status, especially if prophylactic

antibiotics were not given at the initial visit.

● Discuss results of any tests performed.

● Test for pregnancy if indicated. If pregnant, advise about options.

● Remind patients to return for their hepatitis B vaccinations in 1 month and 6 months, other immunizations as indicated, and HIV testing at 3 and 6 months or to follow-up with their usual health care provider.

● Make follow-up appointments.

● Assess the patient's emotional state and mental status, and encourage the patient to seek counselling if they have not yet done so.

The 3-month follow-up visit

At 3 months post assault:

● Test for HIV. Make sure that pre- and post-testing counselling is available or make the appropriate referral. Assess pregnancy status and provide advice and support.

● Discuss results.

● Draw blood for syphilis testing if prophylactic antibiotics were not given previously.

● Assess patient's emotional state and mental status and encourage the patient to seek counselling if they have not yet done so.

Counselling and social support

While the initial medical assessment may not reveal any immediate psychological problems, it is important that a further assessment be conducted to ensure that any issues that may arise are addressed and dealt with appropriately. Counselling services should be provided in a coordinated fashion, and considered in conjunction with similar services provided by schools and other community groups. Thought must also be given to providing support and/or

counselling to those caring for the child. This may be required even if the child itself is not assessed as needing therapy.

In general:

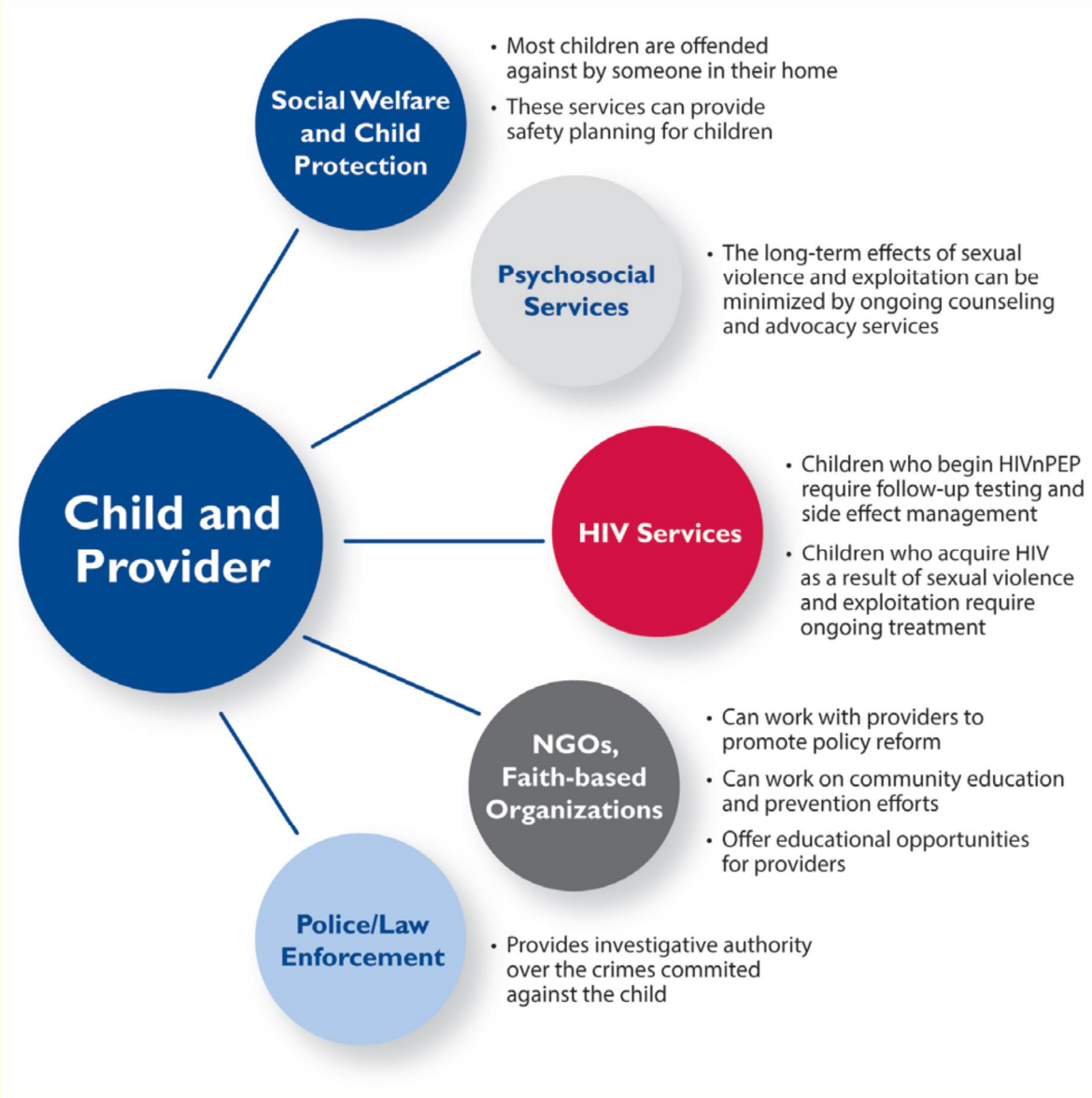
- Abuse-specific cognitive behavioural treatment is generally the most effective form of therapy for post-traumatic stress reactions.
- Group therapy for children is not necessarily more effective than individual therapy.
- Many sexually abused children may have co-morbid conditions that require
- specific treatment.
- Younger children may not understand the implication of abuse and therefore may appear to be less distressed than older children.
- A believing and supportive mother or non-offending caretaker can be a strong determinant for a good prognosis.

Key actors and Services available for survivors

Although the main role of health service providers is to lead medical management for the child,making sure children and families are aware of, appropriately referred to, and able to access additional support services located outside of the health facility is also an important responsibility.Community support services are often provided by a variety of sources including nongovernmental organizations, organizations representing people with disabilities, and faith-based organizations.They may be individuals who provide direct services to children who have experienced sexual violence and exploitation and their families, including police, prosecutors, social services, community shelters and safe havens, legal advice centers, local clinics, women's organizations, and organizations providing psychosocial care. Ensuring strong referral linkages to and from these

providers is a critical, yet often underdeveloped element of clinical post-rape care services.

Communications and Referral Between Health Care and Community Resources



HCPs Role

Health care providers, as professionals with an established infrastructure and scientific base, must take the lead in educating community partners and referral resources on the well-rooted stigma, discrimination, myths, and silence regarding sexual violence and exploitation against children and its life-threatening health consequences.

Acute medical forensic examination and treatment can effectively address prevention of pregnancy, STIs, and HIV, but much of the child's psychological recovery will occur in the months and sometimes years following the sexual violence and exploitation through their ongoing work with advocacy, social welfare, and counseling services.

The following list outlines suggested interventions to be implemented by health service providers in order to establish or strengthen referral linkages to existing community-based psychological and social support services.

• Encourage and provide routine exchange visits with expert providers in child sexual violence and exploitation with the goal of improving the health response.

• Conduct participatory community mapping to identify service providers in the community to whom and from whom children who have experienced sexual violence and exploitation can be referred for services.

• Develop a formal community directory for sexual violence and exploitation services for children and distribute copies to all health providers working with children.

• Build and formalize relationships with referral institutions, including setting up formal referral and counter-referral systems.

• Develop formal and informal protocols regarding standards for confidentiality, service delivery, data collection, and/or collaborating more closely on projects and activities.

• Set up formal referral systems with built in tracking mechanisms.

• Develop algorithms of care that include follow-up appointments and referrals to external service providers.

• Develop referral systems to facilitate and track use of referral services.

• Conduct community outreach activities to ensure that communities are aware of services available to children who have experienced sexual violence and exploitation and how to access them.

• Develop communication material for community and clinic-based awareness.

• Create community and service provider education to increase sensitivity and understanding of appropriate response.

Health providers serve as gatekeepers for children who have experienced sexual violence and exploitation. These children require intervention from a coordinated and skilled team of health professionals, social workers, and nongovernmental organizations, including organizations representing people with disabilities, staff, and volunteers for psychological and social support.

References and Recommended Reading

1. AIDSTAR-One. (Feb. 2012) The Clinical management of Children and Adolescents who have Experienced Sexual Violence; *Technical Considerations for PEPFAR Programs*.

2. World Health Organization. (2003). *Guidelines for medico-legal care for victims of sexual violence*. Geneva, Switzerland: Gender and Women's Health, Family and Community Health Injuries and Violence Prevention, Non-communicable Diseases and Mental Health

3. Ministry of Health. (2014). National Guidelines on Management of Sexual Violence (3rd Edition). Kenya

4. MOH (2014) National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya. Nairobi, Kenya: German development Cooperation

APPENDIX 5. SECOND CURRICULUM REVIEW WORKSHOP REPORT AND PARTICIPANT LIST, APRIL 2015

<table>
<tr><td colspan="2">Type of Event: Curriculum Retreat to Integrate PEPFAR Technical Considerations into National SGBV Curriculum</td></tr>
<tr><td>Submitted by: Peter Shikuku</td><td>Date submitted: 28th April, 2015</td></tr>
<tr><td>Venue: Lukenya Getaway</td><td>Participants;
Peter Shikuku
Juith Karia
Ian Wanyoike
Janet Makena
Others - See the attached list at the end of the report.</td></tr>
<tr><td>Meeting dates; 20th – 24th April, 2015</td><td>Cleared by: Peter Milo</td></tr>
<tr><td colspan="2">Purpose/Goal of the Workshop
1. To integrate PEPFAR Technical Considerations into National SGBV Curriculum

Objectives of Workshop:
1. For participants to be familiar with the current context of SGBV service provision for children and adolescents, both globally and in Kenya
2. Appreciate the rationale and justification for inclusion of PEPFAR Technical Considerations in the curriculum and SGBV response in Kenya
3. Develop knowledge based assessment instruments for the course
4. Develop skills based assessment instruments for the course (checklist for assessment of child and adolescent friendly competencies)
5. Develop job aides/service provision protocols (facility preparation checklist, medical and forensic management and psychosocial support)
6. Write a course schedule for the proposed training course</td></tr>
<tr><td colspan="2">IR Activity contributing to: This was an activity funded by USAID OHA office to support integration of PEPFAR Technical Considerations - to include of children and adolescents issues into national SGBV curriculum. The activity also aimed to strengthen capacity of 6 Counties in APHIAplus Zone 4 (KAMILI) in SGBV response particularly on issues of children and adolescents</td></tr>
</table>

a) IR activity: Curriculum review retreat for the national training programme for SGBV reponse

b) Activity indicator;

- Development of a module for children and adolescents
- Development of checklists to assess service provider competence in provision of SGBV services to children and adolescents
- Development of job aides/service provision protocols to assist in effective service provision
- Development of pre and post test questions for the module
- Development of a course schedule for the module

Number of participants and organizations represented – 32 Particiants from MOH, FUNZOKenya, APHIAplus KAMILI, LVCT, Nairobi Womens Hospital & Physicians for Human Rights (PHR)

Background:

CapacityPlus is the USAID funded global project uniquely focused on the health workforce needed to achieve the MDGs. CapacityPlus has worked in SGBV in several regions and countries in both support for training systems and service provision. AIDSTAR-One publication (PEPFAR Technical Considerations) provides invaluable guidance to training programs on SGBV focusing on children and adolescents survivors of sexual violence. FUNZOKenya trained 50 TOTs and SGBV service providers in the APHIAplus Zone 4 (KAMILI) in 2012. OHA USAID office in Washington provided support to FUNZOKenya to build on this work and to focus on Health Systems Strengthening for SGBV training in Kenya, with the following objectives:

1. build on work already done by the USAID APHIA+ and LVCT Health projects; specifically at the county level in APHIAplus Zone 4 (KAMILI) – Training of TOTs and SPs
2. Orient TOTs and SPs on TCs to better address the needs of children and adolescents
3. Support integration/development of supplementary curricula materials on children and adolescents to be augmented within the national curriculum for SGBV service providers
4. Develop job aides and other tools to support service provision for children and adolescents

A post training assessment was conducted in APHIAplus zone 4 (KAMILI) of the 30 ToTs and service providers trained in 2012 in response to objective 1, to ascertain the status of SGBV service provision by the trainees, their challenges and competence in provision of service to children and adolescents.

This workshop was organized to support attainment of objectives 3 and 4 above.

Key Highlights of the workshop:

The workshop was opened by Dr. Ng'ang'a Programme Manager Gender at the Reproductive and Maternal Health Services Unit (RMHSU) MOH who made the following remarks on the situation of SGBV response in Kenya:

- A reduction was noted in maternal and child health indicators in KDHS 2014

- SGBV data was collected in the last Demographic Heath Survey (DHS) to monitor prevalence of SGBV in the Kenyan society and design appropriate interventions, additionally SGBV data indicators is now included and DHIS2
- The National Guidelines and Standard Operating Procedures on Management of Sexual Violence were developed and revised in 2014 respectively
- MOH is subsequently reviewing its SGBV curriculum to conform to the new guidelines. Issues of children and adolescents will be integrated in this new revision
- A Communication strategy for SGBV is under development, initially there was one for RH, the new one will include SGBV issues
- Children and adolescents are unique, so their approach must be unique

The workshop then continued with the following proceedings:

1. Carol Ajema, the consultant shared the desk review and assessment report and was well received; the findings resonated with participant's experiences. The general feeling is that there is need for capacity building for providers and facilities to be more responsive to SGBV issues for children and adolescents
2. Participants were then invited to look at the PEPFAR Technical Considerations and examine what they recommend in closing some of the existing gaps in service provision. The areas of focus were:
    - Service providers' competencies in provision of SGBV to children and adolescents?
    - Facility setting, infrastructure and equipment for child and adolescent friendly services?
    - Medical management for children and adolescents?
    - Collection of forensic evidence for children and adolescents?
    - Psycho social support – counselling and rehabilitation for children and adolescents?
    - Our general observation is that participants found the guidelines very useful and relevant in addressing some of the gaps they currently experience in the provision of SGBV services to children and adolescents.
3. The LFP model was presented as an approach to training that goes beyond assessing service provider competency to include the work environment as an important element in determining health worker performance. The constraints/barriers at work place must be addressed alongside service provider competency for quality service provision. Participants were introduced to LFP tool 3, performance worksheet and requested to use it to assess, the status of services at their facilities/counties. Participants were divided into counties for the purpose of this exercise. 7 counties were represented as follows - Machakos, Kitui, Makueni, Tharaka Nithi, Embu, Meru and Nairobi. Our finding is that besides Kitui, all the other counties are faring very badly on all the aspects apart from Kitui (which is supported by LVCT Health) and require a lot of

support.

4. The module on children and adolescents whose development had started in Sawela - a previous workshop led by MOH to review the entire SGBV manual ensued. Participants were taken through the module and requested to critique it based on the competencies they had identified from the TCs and gaps/barriers experienced at work place, revisions were made as proposed

5. The development of checklists for the practicum and job aides to enhance service provision was done in groups and presented in plenary for critique and finally ratified

6. A course schedule for the training and some samples questions for the knowledge assessment component of the module were also developed

7. The workshop was closed by Dr. Kigen, Head RMHSU, who appreciated the good work done by FUNZOKenya and committed continued MOH support in initiatives geared to support our people.

Way Forward:
The Actvities of this workshop were integrated within the RMHSU activities on the review of national curriculum as follows:

Activity	By when	By Who
Consolidation/compilation of draft curriculum	3rd April	Peter Shikuku (done)
Child and adolescent module workshop	20th – 24th April	FUNZOKenya and Dr. Ng'ang'a (done)
Consolidate outputs of child and adolescent workshop (Module, checklists, job aides etc.)	28th – 1st April	Carol Ajema
Smaller group to review the draft	6th – 8th May	Dr. Ng'ang'a
Integrate feedback from review into document	11th – 15th May	Peter Shikuku
Send to external reviewer	16th – 29th May	Dr. Ng'ang'a
Validation meeting	June	Dr. Ng'ang'a
Pre – test/piloting	July	Dr. Ng'ang'a
Meeting to discuss pilot findings	July	Dr. Ng'ang'a
Integrate feedback from pilot into document	August	Peter Shikuku
Proof reading, printing and publishing	August	Dr. Ng'ang'a
Launch	September	Dr. Ng'ang'a
Training of TOTs – National level	October	Dr. Ng'ang'a

Training of TOTs – Country level	October	Dr. Ng'ang'a
Partners Cascade training	November onwards	

Distribution list: James Mwanzia, Peter Milo, Josephine Mbiyu, Joyce Kinaro and FUNZOKenya Team

Participant List

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APPENDIX 6. INVITATION LETTER FOR RMHSU VALIDATION MEETING

MINISTRY OF HEALTH

Telegrams: "FAMHEALTH", Nairobi
Telephone: Nairobi 725105/6/7/8
All correspondence should be addressed to the Head.
When replying please quote

REPRODUCTIVE & MATERNAL HEALTH SERVICES UNIT
MBAGATHI ROAD (OLD)
P.O. Box 43319
NAIROBI

Ref: RMHSU/GHR/4/VOL. **01st July 2015**

RE: VALIDATION MEETING ON REVISED SGBV CURRICULUM

The Government of Kenya recognizes Sexual and Gender Based Violence as a serious human rights development issue. Raising awareness and capacity building is one of the multisectoral strategies of addressing rising cases of sexual violence in Kenya

The Ministry of Health through the Reproductive and Maternal Health Services Unit (RMHSU) is mandated to train health care workers on management of survivors of sexual violence. The policy guidelines on management of sexual gender based violence were recently revised in 2014. In line with this, a review of the curriculum was undertaken to be in tandem with the changed policy environment.

The curriculum consists of several modules to ensure health workers are competent in handling survivors of sexual violence. The revised version now includes a module on children and adolescents that was previously missing.

The draft curriculum has undergone external review by persons from relevant disciplines. The next stage is pilot of the curriculum to ensure its practicality.

In this regard, a validation meeting is planned on **7th July 2015** for stakeholders to give their final inputs before the pilot.

The meeting will be held at **Panafric Hotel from 8.30am to 5.00 pm.**

The purpose of this letter is to invite you for this validation meeting as a key stakeholder.

Kindly confirm attendance to Dr. Anne Ng'ang'a on email anniewambui@gmail.com.

Thank you for your continued support.

Dr. Kigen Bartilol
Head, Reproductive and Maternal Health Services Unit

APPENDIX 7. REPORT ON PILOT APPLICATION

<table>
<tr><td colspan="2">Type of Event: SGBV curriculum pilot: Module 6, Children and Adolescents</td></tr>
<tr><td>Submitted by: Ian Wanyoike- Regional Hub Manager Western</td><td>Date submitted: 30 June 2015</td></tr>
<tr><td>Venue: PCEA Milele Guest House, Nairobi</td><td>Participants:
1. Thomas Maluki- MoH Trainer
2. Joseph Kaberia- MoH Trainer
3. Agatha Muturi- MoH Trainer
4. Caroline Mwaniki- APHIAplus Kamili SGBV TO
5. Ndindi MutisyaLVCT
6. Carolyne Ajema- Consultant
7. 12 Service providers from Eastern
<u>FUNZOKenya</u>
8. Peter Milo
9. Peter Shikuku
10. Judith Karia
11. Janet Makena
12. Ian Wanyoike</td></tr>
<tr><td>Trip /Meeting Dates:
23 – 26 June 2015</td><td>Cleared by:
Josephine Mbiyu</td></tr>
</table>

Purpose/Objective(s) of Activity/Meeting:

- Pilot module 6 of the SGBV curriculum developed with support from the OHA SGBV project to assess the following:
    - Relevance and adequacy of content
    - Effectiveness ofvtraining methodology in imparting intended competencies
    - Logical sequencing of content
    - Sufficiency of time allocated for the module
    - Usefulness of service provider protocols and alogorithmns in enhancing service provision
    -

IR Activity contributing to:

- Improve service providers response to children and adolescents who have experienced sexual violence

Number of participants and organizations represented (Where Project or partner organized the activity)

- MOH- 15 , APHIAplus Kamili-2, FUNZOKenya-5, 1 consultant

Background:

Intrahealth International through its projects Capacity Plus and FUNZOKenya received a grant from PEPFAR to review training materials on SGBV to incorporate PEPFARs Technical Considerations in Clinical management of children and adolescents who have experienced Sexual Violence. Having undertaken a gap analysis, the project through working with RMHSU and other stakeholders influenced the incorporation of a module that focuses on children and adolescence in the national curriculum currently on its final stages of development and spearheaded the development of the module with providers and trainers in SGBV. The 3 day piloting meeting therefore served as an opportunity to pilot the module with service providers.

Major highlights:

- Organization of the workshop- The 3 day workshop was organized into two major session with the facilitators meeting on the first day to review the module, acquaint themselves with the training materials and undertake teachback sessions in preparation of facilitiating the sessions the following day. The team also reviewed the training slides and proposed some changes as below
    - In addition to the definition provided for consent, a definition for assent to be included
    - The slides on psychosocial history taking could be revised to be more aligned to the title. The difference between psychosocial and psychological history taking to be elaborated
    - The Tanner Stages of Sexual maturation slides could be moved to the unit on physical examination and psychological assessment
    - The team incorporated more role plays in the teaching methodology to replace video clips in order

to allow for more skills practice

- The service providers reported on the 2nd day and were taken through the modules by the facilitators for 2 days

Recommendations for curriculum improvement

- There is need to incorporate more activities that enhance skills such as role plays and demonstrations. Additionally the curriculum needs to have more case studies, scenarios and site visits which will enhance competency. The session on physical examination for instance could do with more exercises.
- The content on the slides could be reduced/decongest the slides. The slides could include a key message/tip for each unit/section
- The videos and role plays used need to be specifically for children and adolescents to allow for skills building in dealing specifically with the two
- The national curriculum of which the module is a part of will be validated in early July. Changes in the module need to be inputed to the curriculum before then.

Way Forward:

- Review of the training slides and the curriculum

Distribution list:

OHA SGBV Project team

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