Enhancing Access to Comprehensive Post-Rape Care Services for Children in Kenya

October 2017
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### Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ART</td>
<td>Anti-retroviral Therapy</td>
</tr>
<tr>
<td>CCC</td>
<td>Comprehensive Care Clinic</td>
</tr>
<tr>
<td>CSA</td>
<td>Child Sexual Abuse</td>
</tr>
<tr>
<td>EC</td>
<td>Emergency Contraceptives</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>GBVRC</td>
<td>Gender Based Violence Recovery Centre</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>OPD</td>
<td>Outpatient Department</td>
</tr>
<tr>
<td>P3</td>
<td>Kenya Police Medical Examination Form</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PRC</td>
<td>Post-Rape Care</td>
</tr>
<tr>
<td>RMHSU</td>
<td>Reproductive and Maternal Health Services Unit</td>
</tr>
<tr>
<td>SDP</td>
<td>Service Delivery Point</td>
</tr>
<tr>
<td>SGBV</td>
<td>Sexual and Gender Based Violence</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
**Definition of terms**

**Adolescence:** The World Health Organization defines it as the period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19.

**Child:** The Kenyan constitution defines a child as any person below the age of 18 years.

**Sexual Violence:** The study adopts the WHO definition of sexual violence as any act, attempt to obtain a sexual act, unwanted sexual comments or acts to traffic a person’s sexuality using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting including and not limited to home and work. This definition is expanded to include forced sex sexual coercion and rape of adult and/or adolescent men and women, and child sexual abuse.

**Caregivers:** This study defines caregivers as parents or guardians who accompany survivors of sexual violence to the health facility for post-rape care services.

**Survivor:** A person who has experienced sexual violence.
EXECUTIVE SUMMARY

Health systems have the important role of providing care to mitigate the effects of sexual violence. In Kenya, children form the majority of clients accessing Post Rape Care (PRC) services in health facilities. Regardless, PRC service delivery approaches in Kenya are adult-focussed. Therefore, an intervention was put in place to assess the feasibility of enhancing children’s access to PRC services in two public health facilities in Kenya: Naivasha Sub-County Referral Hospital and Nyeri Provincial Referral Hospital. The intervention was implemented from December 2016 to March 2017 and it included; development of Standard Operating Procedures for health providers, capacity building of health providers, use of case advocates for post-rape care, and development of literacy materials on management of SGBV in children.

The study adopted a descriptive case study design drawing on qualitative and quantitative methods. Purposive sampling was used to select study participants including: 27 caregivers, 14 children, and 33 health service providers. Data analysis was done using Nvivo 11 for qualitative data and SPSS 22 for quantitative data.

The study findings showed that the case advocate was the most critical component of the intervention with benefits for children, caregivers, and health providers. Caregivers and children appreciated the resulting expedited services and the liaison role played by the case advocates. Health providers enjoyed task shifting and expedited service delivery. Other components of the intervention that were acceptable to health providers were the debriefing sessions and training. The training resulted in improved skills in management of child survivors whereas the debrief sessions addressed PRC services related trauma and provided a platform for cross learning between health providers. There was a strong demand for the intervention by children evidenced by the increase in the number of such survivors receiving various components of PRC during the intervention implementation period.

Recommendations include devising and implementing modalities for integrating case advocates into public health care facilities in Kenya, and strengthening the capacity of responders in health facilities to provide appropriate care to child survivors through training, routine debriefing sessions, and continuous mentorship.
1 INTRODUCTION

1.1 Background of the study

The World Health Organization defines child sexual abuse (CSA) as the involvement of a child in 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 (1). The abuse may include but is not limited to the inducement or coercion of a child to engage in any unlawful sexual activity; child prostitution or other unlawful sexual practices and promotion or involvement in child pornography. Child sexual abuse has been associated with poor mental health outcomes in childhood, adolescence, and adulthood such as post-traumatic stress, other anxiety symptoms, depression and suicide attempts, and behavioural problems (2, 3). Evidence shows that children who have experienced sexual abuse are likely to engage in the use of alcohol and drugs in adolescence and adulthood (4-7), engage in delinquency and crime both as victims and perpetrators (8, 9) and experience behavioural and psychological problems (10-12).

Global meta-analyses studies on CSA put prevalence rates at an alarming 18-20% for girls and 8% for boys (13, 14). In Africa, child sexual abuse rates are even higher (15, 16). A national prevalence survey in Swaziland reported that approximately 33% of females aged 13 to 24 had experienced some form of sexual violence as a child (16). In Tanzania national prevalence estimates from a 2009 survey found that 27.9% of females and 13.4% of males aged 13 to 24 experienced some form of sexual violence as a child (17). In Kenya, child sexual abuse is common with 3 out of every 10 females and nearly 2 out of every 10 males aged 18 to 24 reporting to have had at least one experience of sexual violence prior to age 18 (18). Health facility reports indicate that children contribute to more than half of the cases presented for post rape care health services in the few facilities that offer them (19, 20). The number of children at risk of CSA are much higher than the prevalence rates indicate since many victims of CSA are not recognized (7); due to factors such as lack of disclosure (8).

Health systems have the important role of providing supportive care crucial to prevent recurrence of violence, providing care to mitigate the effects of violence and addressing other problems associated with child sexual abuse (34). There is increased attention to the need for health systems to address sexual violence against children. At the global level, the PEPFAR (President’s Emergency Plan for AIDS Relief) developed Technical Considerations for the Clinical Management of Children who have experienced Sexual Violence in health centres (19). These Technical Considerations are supposed to serve as a guide for primary health providers on the appropriate care of children who have experienced sexual violence and exploitation based on current, evidence-based practices. The focus Technical considerations focus on the delivery of clinical postrape care services, preparing for and performing a head-to-toe physical examination of children who have experienced sexual violence, conducting forensics evidence collection, and ensuring follow-up care and referrals for psychosocial and community support services. Governments are required to adapt these considerations in their endeavour to strengthen responses to needs of child survivors.
The Kenya Ministry of Health (MoH) has made efforts to strengthen the quality of services offered to survivors of sexual violence in the country by developing national guidelines on management of sexual violence in Kenya (21) and a training course for service providers on management of sexual violence. The national guidelines stipulate the core components of a comprehensive response to sexual violence to 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 infections (STI) management; counselling for trauma and; referral for the well-being of survivors (21). (Table 1). The main limitation of these policy documents is that their content is focused on adults and therefore not applicable for the management of child survivors of sexual abuse.

Table 1: Minimum care package for survivors of sexual violence

<table>
<thead>
<tr>
<th>Services</th>
<th>Key components of response provided at the health facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Comprehensive medical examination</td>
</tr>
<tr>
<td></td>
<td>Evidence collection and analysis</td>
</tr>
<tr>
<td></td>
<td>Pregnancy prevention/and or management</td>
</tr>
<tr>
<td></td>
<td>Post-Exposure Prophylaxis (PEP) and or referral for HIV care</td>
</tr>
<tr>
<td></td>
<td>HIV diagnostic testing and counselling</td>
</tr>
<tr>
<td></td>
<td>Prophylaxis for sexually transmitted infections</td>
</tr>
<tr>
<td></td>
<td>Evaluation and treatment of injuries, forensic examination and documentation</td>
</tr>
<tr>
<td>Psychological support</td>
<td>Long-term psychosocial counselling and rehabilitation</td>
</tr>
</tbody>
</table>

1.2 Rationale

A previous study carried out by LVCT Health in two public health facilities reported the following as factors associated with poor uptake and quality of post-rape care (PRC) services the Nyeri and Naivasha County hospitals:

1) Limited knowledge on extent to which service providers utilise existing national protocols in a manner that is beneficial to the survivors and in a comprehensive manner;

2) Providers insufficiently trained to address the needs of children and adolescents who have experienced sexual violence;

3) Challenges in children negotiating through the various service delivery points to access services and waiting for long before being attended to,

4) lack of privacy in the delivery of services to children;

5) Public lack of awareness of health risks associated with sexual violence and services available;
6) Lack of structured mentorship sessions to facilitate provider acquisition of knowledge without interfering with routine service delivery; and,

7) Provider trauma resulting from them unconsciously assimilating the distress experienced by the survivors (44). This study therefore sought to assess the feasibility of enhancing child survivors’ access to comprehensive post-rape care services through a package of interventions designed to address the gaps previously identified.

1.3 Goals and Objectives

The goal of the study was ‘to enhance children’s access to comprehensive post-rape care services in Kenya.’

Objective

The study’s specific objective was to assess the feasibility of enhancing children’s access to health facility-based PRC services in low-resource settings in Kenya. Two selected dimensions of feasibility were assessed:

a. Acceptability: The extent to which the intervention for enhancing children’s access to comprehensive PRC was judged as suitable, satisfying, or attractive to health service providers, survivors and/or their caregivers; and

b. Demand: The extent to which the intervention is likely to be used by children and their caregivers.
2 STUDY METHODOLOGY

2.1 Study design

The study used a descriptive design drawing on qualitative and quantitative methods.

2.2 Study sites

The study was carried out in two health facilities that offer PRC services: Naivasha County and Nyeri County referral hospitals. The two sites were selected purposively based on the fact that LVCT Health works closely with them and had previously conducted a study at these facilities to identify factors resulting in low quality and poor uptake of services for child survivors of sexual abuse. The two hospitals have health service providers trained by LVCT Health on the management of sexual violence survivors. Additionally, they also receive the greatest number of survivors per month compared to other health facilities associated with LVCT Health. Below are more details on each of the two sites;

2.2.1 Naivasha County Referral Hospital

This is a public hospital located in Naivasha town situated approximately 76kms North West of Nairobi. Administratively, the hospital is in the Rift Valley province under Nakuru County. The hospital has been offering PRC services since 2005. The facility records approximately 40 survivors of sexual violence per month, with the majority being children. PRC services are not offered in a ‘one-stop shop’ model; survivors are required to visit different service delivery points within the hospital to receive all the necessary services.

2.2.2 Nyeri County Referral Hospital

This is a public hospital located in Nyeri town situated 151.37km North of Nairobi. The facility has a Gender Based Violence Recovery Centre (GBVRC) that begun its operations in 2013. The facility records approximately 15 survivors per month. PRC services are not offered in a ‘one-stop shop’ model; survivors are required to visit different service delivery points to receive all the necessary services.

2.3 Study population and sampling methodology

The study population comprised of child survivors, caregivers of child survivors and health service providers. Below is a description of the selection criteria and sampling criteria for each category.

2.3.1 Health service providers

In each of the health facilities, a total of 15 health service providers were purposively sampled to participate in the study. These participants were selected from the various service delivery points where post-rape care services are offered including: outpatient (casualty), comprehensive care
clinical, laboratory, wards, counselling, social work, and pharmacy. The sample size was informed by the number of health service providers involved in delivery of PRC service and budgetary constraints. The selection criteria for health service providers included:

- Direct involvement in provision of services to survivors of sexual violence;
- Willingness to participate in the study; and
- Being on duty during the study period.

2.3.2 Child survivors of sexual violence

Child survivors were purposively sampled to participate in the study. Recruitment of participants was done once the survivors had received all the required services. The selection criteria included: those aged 14-18 years; ability to communicate in English/Kiswahili; and willingness to participate in the study.

2.3.3 Caregivers of child survivors of sexual violence

Caregivers of child survivors were purposively sampled from those who accompanied their children for post-rape care services during the study period. The selection criteria included: guardians/parents above the age of 18 years; those who accompanied a child survivor below the age of 18 years; and willingness to participate in the study.
3 DESCRIPTION OF THE INTERVENTION

The intervention was implemented over four months (December 2016 - March 2017) in the two health facilities. The intervention included training of providers, recruitment of case advocates, development of Standard Operating Procedures on management of child survivors, development of care giver and survivor literacy materials, setting up of child-friendly rooms, debriefing sessions for health service providers and continuous mentorship of health service providers within the time points stipulated below:

Table 2: Duration taken to implement components of the intervention

<table>
<thead>
<tr>
<th>Intervention Component</th>
<th>Period of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment and placement of case advocates.</td>
<td>January to March 2017</td>
</tr>
<tr>
<td>Training of health service providers and case advocates. This was done in two phases:</td>
<td></td>
</tr>
<tr>
<td>• 5 day training on post rape care management</td>
<td>December 2016</td>
</tr>
<tr>
<td>• 3 day skills and competency based training on management of child survivors.</td>
<td>January 2017</td>
</tr>
<tr>
<td>Development of Standard Operating Procedures on management of child survivors of SV.</td>
<td>January to March 2017</td>
</tr>
<tr>
<td>Development of care giver and survivor literacy materials.</td>
<td>January to March 2017</td>
</tr>
<tr>
<td>Setting up of child-friendly rooms.</td>
<td>January to March 2017</td>
</tr>
<tr>
<td>Debriefing sessions for health service providers.</td>
<td>February to March 2017</td>
</tr>
<tr>
<td>Continuous mentorship of health service providers.</td>
<td>February to March 2017</td>
</tr>
</tbody>
</table>

a. Recruitment and placement of case advocates (January to March 2017)

In order to facilitate survivor access to services offered at different service providers, case advocates were recruited. The case advocates were identified by the hospital administration from a pool of student interns who had previously been attached to the health facility. The advocates were sensitised on the post rape care services and were tasked with the following responsibilities:

• Linking up with the health providers at the facility triage desk to facilitate easy identification of child survivors of sexual violence,

• Escorting survivors to the various service delivery points to ensure that they do not queue for services,

• Making phone follow ups to remind survivors of their care givers of scheduled visits to the health facility, and
A total of three case advocates were engaged—two in Naivasha and one in Nyeri. The three case advocates were also tasked with observing and documenting all the services received by each child survivor who visited the hospital during the intervention period. A checklist was utilized for this documentation. The case advocates observed and documented services received by a total of 29 survivors.

b. Training of health service providers and case advocates

A total of 31 health providers drawn from the two health facilities underwent a 5-day training session on general post-rape care, using the national curriculum on the clinical management of survivors of SV. They later on underwent a follow up 3-day skills and competency-based training on the management of child survivors of sexual violence.

The learning outcomes of the 3 day training are as highlighted below:

- Develop an understanding of the psychosocial support required by child survivors of sexual violence to enable them cope with the trauma.
- Be equipped with requisite skills for conducting physical examination, history taking, counselling, evidence collection and maintenance of the chain of custody.
- Develop an understanding of survivor referral pathways within and outside the health facility.
Table 3: Number and cadre of providers trained

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Designation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adherence counsellor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical officer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laboratory Technologist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Occupational Therapist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurse</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharmacist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Case Advocate</td>
<td></td>
</tr>
<tr>
<td>Nyeri county referral hospital</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Naivasha county referral hospital</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

c. Development of Standard Operating Procedures on management of child survivors

LVCT health in collaboration with the Ministry of Health (MoH) through the Reproductive and Maternal Health Services Unit (RMHSU) convened a 3-day stakeholders meeting to draft Standard Operating Procedures (SOPs) for management of child sexual abuse. The components of the SOPs included:

- SOP 1: Taking consent from a child survivor
- SOP 2: Medical history and clinical examination
- SOP 3: Forensic evidence collection and chain of evidence management
- SOP 4: Providing psychosocial support
- SOP 5: Referral and linkages

Providers involved in the delivery of services to child survivors in the two health facilities were sensitized on the above SOPs.
d. Development of care giver and survivor literacy materials

We developed IEC materials targeting child survivors and their caregivers. The IEC materials highlight the services available and what is expected of survivors and their care givers.

Child survivors of sexual violence in a support group that is facilitated by LVCT Health at the Kenyatta national referral hospital were consulted to help inform the language of the materials. The aim of this consultation was to ensure the materials can easily be understood by the children and caregivers.

![Figure 1: IEC materials for children and caregivers](image)

e. Setting up of child-friendly rooms

In order to facilitate providers to offer services to children in a private setting, the study team negotiated with the health facility management teams in both health facilities for the provision of a play area and waiting bay for child survivors. The rooms were transformed into safe spaces that would inspire fun and play for children. The renovations that were done included:

- Fitting the walls with attractive wall paper
- Providing chairs and tables for use by children
- Provision of toys and fluffy animals
- Provision of drawing books for art therapy

![Image of child-friendly room](image)
f. Debriefing sessions for health service providers

The LVCT Health supervision team developed a debriefing framework informed by Kenya’s HIV counselling and testing quality assurance standards. Providers in each of the study sites developed a schedule that facilitated the convening of monthly group debriefing sessions. These were sessions that were aimed at providing a forum where the health service providers could share some of their experiences and challenges encountered in their management of child survivors and help each other debrief from any traumatic experiences. The debriefing sessions were facilitated by two trained counsellors certified by the National STI and AIDS Control Program (NASCOP) and with experience in conducting counsellors’ supervision. A total of 7 debriefing session were conducted for 31 providers involved in the delivery of services to child survivors. These providers included 2 trauma counsellors, 6 clinical officers, 2 laboratory technologies, 2 occupational therapists, 11 nurses, 1 pharmacist, 3 social workers, and 4 case advocates. Each debriefing session was composed of between 6-8 members and lasted for 2 hours.
The debriefing sessions permitted providers to do the following:

1. Share their reactions and feelings in relation to the cases they had attended to.
2. Offer support to each other in coping with mental distress arising from attending to child survivors of sexual violence.
3. Flag up any challenges they experienced in offering services or areas in which they required further mentorship.

**Continuous mentorship of health service providers**

Continuous mentorship was offered by LVCT Health PRC officers to 10 health service providers involved in delivery of PRC services to child survivors in the two study sites. The 10 health providers were in turn empowered with skills to enable them mentor/ build the capacity of their colleagues involved in delivery of post rape care services to children (Figure 3 below). These sessions were conducted through monthly continuous medical education sessions and focused on the different aspects of management of the child survivors. The facility mentors were selected by the heads of the various services delivery points and included providers who are on a routine basis actively involved in post rape care service delivery. The mentors were drawn from various service delivery points within the health facilities, namely: Outpatient department (2), Laboratory (2), Pharmacy (1), Wards (2), Youth friendly clinic (1), Physiotherapy/Occupational therapy (1), Gender based violence recovery clinic (1).

![Mentorship schematic](image-url)

**Figure 3: Mentorship schematic**
4 DATA COLLECTION AND MANAGEMENT

4.1 Data collection procedures

The study used a mixed methods approach which combined both qualitative and quantitative methods. Data was collected throughout the study period from January to April 2017.

i. Qualitative data collection methods

Focus Group Discussions (FGDs) and In-depth Interviews were conducted with study participants. Four FGDs were conducted with providers to explore their perceptions of the acceptability and usefulness of the intervention in the provision of PRC services to children. Fourteen In-depth interviews were carried out with child survivors and 26 with caregivers of such survivors to determine the suitability and attractiveness of the intervention to them.

ii. Quantitative data collection methods

A record review questionnaire and an observation checklist were utilized. The observation checklist was used by the case advocates to record services received by each child survivor who presented at the facility during the months of February and March 2016. A total of 29 checklists were completed by the case advocates. A record review questionnaire was designed to retrieve information on of PRC services offered to child survivors across as documented in the: PRC forms, GBV register, Counselling forms, Laboratory Registers, and Pharmacy registers. A total of 106 child survivor records were reviewed.

Table 4 below provides a summary of the data collection procedures

<table>
<thead>
<tr>
<th>Participant type</th>
<th>Data Collection method</th>
<th>Actual Number of respondents/ records Naivasha</th>
<th>Actual Number of respondents/ records Nyeri</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health service providers</td>
<td>Focused Group Discussions per facility)</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Caregivers</td>
<td>In-depth interviews</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Child Survivors</td>
<td>In-depth interviews</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Record reviews</td>
<td>60</td>
<td>38</td>
</tr>
<tr>
<td>Case advocates</td>
<td>Case advocate observation checklists</td>
<td>16</td>
<td>13</td>
</tr>
</tbody>
</table>
4.2 Data entry and quality assurance

Data entry for the quantitative data was done using SPSS version 22. Data entry was done concurrently with data collection to ensure that errors were noted early and rectified. Data was cleaned and validated prior to analysis.

Qualitative data was transcribed into Microsoft Word. The quality of transcripts was checked against the audio files to ensure that the original meaning and content was maintained.

4.2.1 Data Analysis

All the data generated in this study were coded prior to analysis to enhance confidentiality.

Descriptive analysis of the quantitative data was undertaken using SPSS analysis. The parameters were informed by the comprehensive package of care as stipulated by the National Guidelines for management of survivors of sexual violence [21]. These findings informed the objective on Demand; the extent to which the intervention is likely to be used by children and their caregivers. Descriptive analysis was done on categorical variables presenting counts and corresponding proportions while for the continuous variables (age) median (SD) or Median (Interquartile Range) were presented as deemed appropriate. The variables used to describe clients included: sex, age, type of sexual violence, and health facility used.

All the qualitative interviews were transcribed and analyzed using NVIVO 11 (Qualitative analysis software). A thematic coding framework was developed by the study team based on the feasibility dimension of Acceptability – i.e., the extent to which this intervention for enhancing children’s access to comprehensive PRC was judged as suitable, satisfying, or attractive to health service providers, survivors and/or their caregivers.
5 ETHICAL CONSIDERATIONS

This proposal was ethically appraised by the Population Council Institutional Review Board in New York and the AMREF Ethics & Scientific Review Committee (ESRC) in Kenya.

Informed Consent

In this study, each participant’s choices and opinions were considered and all project staff refrained from hindering or influencing the actions of participants. To ensure that participants made informed choices they were verbally informed about the study objectives, process, procedures, requirements, benefits, risks, how the findings were utilized, and encouraged to ask questions and seek clarification. All participants were informed that participation was voluntary and that they could stop taking part in the study at any time. Consent forms were provided to all participants, and were read aloud to them to ensure they understood what the study entailed. The consent forms were availed in English and Kiswahili to give participants an opportunity to choose the language they were most comfortable with. All individuals who were willing to participate in the study were requested to voluntarily sign or append their thumb print to the informed consent form.

The study included children aged 14-17 years and additional protection was provided to them as guided by National Guidelines for conducting HIV and SRH Research with adolescents in Kenya (NASCOP and KEMRI, 2015). More details are provided in the next section on safeguard for children below.

Safeguard for vulnerable population (Children)

The Kenyan law provides that minors need to have the consent of a parent or guardian. Parents and guardians accompanying children to the hospital for Post rape care services were asked to give their informed consent to allow the child survivors to participate in the study. In addition, assent was requested from all children (13-17 years) prior to their involvement in the study. The study ensured additional protection for children as follows: (1) The study PI’s ensured that all research assistants were trained on skills to interview children; (2) research was conducted in circumstances that provide for the physical, emotional and psychological wellbeing of the minor. The children were given an option to allow their parents/ guardians to sit in during the interview to ensure that they felt safe.

Risks and mitigating steps

The questions in this study were focusing on health service and not the event/ occurrence of child sexual abuse. However, due to the traumatic effects associated with defilement some participants (both survivors and caregivers) experienced discomfort discussing their experiences in the hospital. To minimize distress the research assistants were asked to refrain from encouraging any discussions on the occurrence of rape and where participants became distressed interviews were discontinued and participants referred to the health service providers for counselling services. Research Assistants in the study were selected due to their training and experience in conducting interviews to minimize
discomfort to respondents. The training provided to research assistants in the study addressed potentially sensitive issues/aspects, the need for empathy and, if needed, referral for counselling at the health facility.

**Confidentiality protection**

To reinforce the confidentiality all study participants’ personal identifiers such as names were not recorded on the questionnaires or other study outputs such as reports or transcripts. Each questionnaire or transcript was given an identification number to be used in place of his or her name on the interview form. Access to data on hard copy and electronic databases was limited to the study team members and safely kept under locked cabinets and password protected computers. In addition, audio recordings were made using Dictaphones, securely stored, and labelled using pseudo names for privacy purposes. The audio files were deleted once the transcription process and validation of transcripts was complete. To encourage confidentiality among FGD participants, each participant was requested not to discuss what other participants said during the sessions.

6 FINDINGS

6.1 Description of study participants

6.1.1 Characteristics of participants interviewed

A total of 27 caregivers participated in the study, majority of which were female (n= 24). Most of the caregivers (n=22) were biological parents of the child survivors that they had accompanied to the hospital. The caregivers’ average age was 36 years. Table 5 and Table 6 below show more information on caregiver characteristics.

<table>
<thead>
<tr>
<th>Caregiver characteristics</th>
<th>Number (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>27-65 years</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
</tr>
<tr>
<td>Relationship to child</td>
<td></td>
</tr>
<tr>
<td>Biological parent</td>
<td>22</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>Health facility</td>
<td></td>
</tr>
<tr>
<td>Nyeri</td>
<td>13</td>
</tr>
<tr>
<td>Naivasha</td>
<td>14</td>
</tr>
</tbody>
</table>

A total of 14 female child survivors who presented for services during the study period and were willing to participate were included in this study. No male survivor reported at the health facility during the study period.
A total of 33 health service providers participated in the study and most were female (n=20). A majority (n=21) had received training on management of child survivors of sexual violence. The average years of service in post rape care was 4 years. Table 7 below gives more details on health service providers’ characteristics.

### Table 6: Demographics of child survivors interviewed

<table>
<thead>
<tr>
<th>Child characteristics</th>
<th>Number (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Age range</td>
</tr>
<tr>
<td></td>
<td>14-18 years</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Health facility</td>
<td>Nyeri</td>
</tr>
<tr>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Naivasha</td>
</tr>
<tr>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

6.2 Acceptability of intervention to study participants

This section examines the extent to which the intervention was deemed acceptable (i.e., suitable, satisfying, or attractive) by the survivors and/or their caregivers and health service providers.

6.2.1 Acceptability of Intervention to Children and Caregivers

All (n=27) the caregivers and child survivors who were interviewed expressed satisfaction overall with their experiences in seeking post-rape care. Their satisfaction centred primarily on processes
that were made possible by the presence of case advocates within the health facilities. For instance, a key area of satisfaction for child survivors and caregivers alike had to do with their not having to queue for the services. As the following respondents indicated:

“[I appreciated] the way they [hospital staff] understood me and gave me fast services.” *(Naivasha, Child)*

“If I had gone (gone for PRC services by myself without a case advocate), it could have taken a lot of time before I was offered service. I saw that it was quite good because she (case advocate) took me.” *(Nyeri, Child)*

“I was pleased with the way they took me {and child} in fast; and also gave fast services.” *(Naivasha Caregiver)*

“For instance at the place for registration, we did not need to queue; also at the doctor’s we did not need to queue... we were treated fast because he (case advocate) was there.” *(Naivasha Caregiver)*

The expedited service delivery described by respondents occurred because they were accompanied by case advocates who served as liaisons between child survivors and the health system. Study findings indicate that when case advocates were absent (i.e., at night and on weekends), survivors and caregivers experienced longer waiting periods and expressed their dissatisfaction with this situation. As pointed out by one caregiver who sought post-rape care for a child survivor in the absence of a case advocate:

“The only improvements I can say I would like to see is at the lab. At the lab we took time; I think the staffs are few but the patients are many so that is where we took long.” *(Naivasha Caregiver)*
The liaison role played by case advocates involved communicating about cases with providers on behalf of survivors and caregivers, picking up test results, and escorting survivors and shepherding survivors from one service delivery point to another, among other tasks. These roles resulted in psychological and physical relief for survivors and caregivers and much of their satisfaction therefore revolved around this constellation of tasks.

Caregivers and child survivors appreciated that case advocates represented their needs. The role that the case advocates played in guiding and escorting caregivers and survivors through the health system, presenting the traumatic cases to providers at multiple service points, and standing in for survivors was particularly valued:

“That (being escorted by a case advocate) was very helpful because, if we were to go by ourselves we would be asking where do we go and we did not need to explain to everybody what happened...we had somebody taking us from one point to another.” (Nyeri Caregiver)

“...one can visit the hospital for the first time and doesn’t know what to do. That process is very important because you can come from here; from the gate and you are not sure where to go.... You are not sure if you are supposed to start at the cashier first, so it is good to be directed. It also doesn’t take time because if I was the one going back and forth alone, I wouldn’t go at the right place; I would just enter anywhere for me to be directed again.” (Nyeri Caregiver)

“You can be a visitor here there and not know the procedure so when they escort you, you feel assisted. It is important (to be escorted by a case advocate) because you have never been to the hospital before and you don’t know where to start or where to go to. It makes it easy by saving time and ensuring one gets to the doctor fast.” (Naivasha Caregiver)
“There is an importance (of being escorted by a case advocate) because for instance if I am alone with my child who is in pain and I go there to a service delivery point, the doctor might not realize the situation. But if you have someone directing you, the person will enter and explain why it is an emergency.” (Naivasha, Caregiver)

“It is important (to be escorted) because some people may not be able to communicate with those people (hospital staff) about their information...the victims sometimes they don’t have courage to say what happened.” (Nyeri Child)

“It helps (to be escorted by a case advocate) because some children might be confused (following the rape incidence)... it’s like the person (case advocate) is protecting you. (Naivasha Child)

“I feel it assisted me because the person (case advocate) picked my results for me and I and my child did not have to fetch them ourselves because my child was in pain and we could not move with ease... I feel it was easy, because I didn’t take a long time. (Nyeri Caregiver)

Care givers noted that case advocates were well-known to, and a legitimate part of, the health facility – a status that was perceived to give case advocates some advantage over clients. This status eased the access of case advocates to the health system, and in turn, granted child survivors enhanced access to post-rape care services.
“If I had gone alone, it could have taken a lot of time before I was offered service. I saw that it was quite good because she took me.”  *(Nyeri Child)*

“(What pleased you when you visited the hospital?) At the card section the person escorting me (case advocate) ensured that I did not queue, the service was also fast.” *(Naivasha Child)*

Furthermore, as a caregiver observed, the case advocate role was all the more crucial given the time-bound nature of PRC services. Case advocates helped ensure the timely receipt of such services by child Survivors:

“It is very important (to have an escort) because this is something that you need to save time … If it is the PEP, you are supposed to get it within hours for it to be effective. That taking somebody round, it is very important because you can lose a lot of time until the 72 hours are over and you have not finished the process.” *(Nyeri Caregiver)*

### 6.2.2 Acceptability of Intervention to Health Service Providers

#### a) Health service provider views on case advocates

The satisfaction of health service providers with the introduction of case advocates into the health system mainly revolved around task-shifting. Providers explained that the case advocate took up some of the roles previously carried out by the health service providers, such as follow-up of clients and escorting the survivors to the various services delivery points:

“She (Case advocate) came in handy because providers have a lot of work. You do the trauma counselling, escort the patient, waiver system, refill of the PEP.” *(Nyeri Health Service Provider)*
Other tasks shifted from health providers to case advocates included the proper documentation of child survivor demographic information in the national SGBV register and picking of survivor’s tests results from the laboratory. As case advocates took over this role, health providers felt empowered to concentrate on clinical work and counselling.

“They (case advocates) are important because you see if there is no data (on a PRC client) it’s like services were never given. What I have liked about them (case advocates) is that they ensure the data in the PRC form and in the SGBV register is the same and also they are able even to go through the trauma counselling forms and check whether the client came back (for follow-up visits) and point out if I forgot to fill in the forms.” *(Naivasha Health Service Provider)*

Like child survivors and caregivers, health providers also recognized the role that case advocates played in easing survivors’ entry into, and flow through, the health system. They acknowledged the communication difficulties that child survivors faced in engaging with the health system, as well as the promptness with which survivors received care when in the company of case advocates:

“It’s useful (case advocate role) because the clients... they kind of don’t feel embarrassed going to those areas and saying their problems. Because she’s the advocate; she spoke for the client and because the departments are familiar with her roles, they may not keep asking questions; they just attend to the client…” *(Nyeri Health Service Provider)*

“There used to be a lot of delay (before they had a case advocate), the GBV clients would loiter alone around the hospital but now with the case advocate once I realize it’s a sexual abuse case I ensure clients are seen in a timely way.” *(Naivasha Service Provider)*
Importantly, health service providers noted that the presence of case advocates facilitated the efficient delivery of time-bound PRC services. Providers were able to offer a comprehensive package of PRC services within a day. Prior to the intervention, survivors were obligated to pay several visits to a health facility in order to obtain a full package of services:

“My work has become very easy and I am very happy because in a day’s time, I am able to manage a client. Let me say between 8am and 3pm I can handle a case and complete. Initially, it used to take two days…” (Nyeri Health Service Provider)

“There is a big improvement (since we got a case advocate) like today we had one case and it took less than 30 minutes from the time I first saw her until the time I got the lab results... the duration taken to deliver services has really reduced.” (Naivasha Health Service Provider)

b) Health service provider views on debriefing sessions

According to the health providers who participated in the debriefing, a majority of them cited debriefing sessions as having provided them with a platform to address trauma arising from their daily interactions with child survivors of sexual violence. Many providers stated that these sessions;

“There are been beneficial to me since I am able to pour out my feelings, the emotions I had when I had encountered these SGBV clients. Sharing with other health providers you realized you are not alone they help you to be strong.” (Naivasha Health Service Provider)

“Debriefing sessions have given me a relief, when you hear others have gone through more severe case scenarios than what you have experienced you get encouraged and also get solutions to sort out things that have experienced in attending to children (Nyeri Health Service provider)
A health service provider narrated how she learnt to cope after interacting with a child who had been defiled by a biological father. The traumatic experience had affected her ability to offer services:

“...I realized as one person after the other talked about their experience with individual client they were still bitter even at the time they were talking. I was no different from them because I was talking about a child who had been raped by the biological father and until that day I was still very bitter about the father. ... Well I actually came to learn that there is a better way that you can let things go so that you can be able to handle your next patient in a better way.” *(Nyeri Health Service Provider)*

The debriefing sessions also helped in cross learning between the providers and provided an opportunity to show case best practices to each other. One health service provider pointed out that sharing experiences with colleagues build confidence:

“... I will speak on my own account and someone else on theirs... and then from that you find that from the group they can help you with ideas on how best you can handle a case...so it’s like a team building and you know a problem shared is a problem solved... the next time a case comes you are very confident that you won’t be defeated because cases tend to recur.” *(Nyeri Health Service Provider)*

“I have learnt how I can handle such a case (PRC cases) once I find myself in a similar situation (to the one shared by a colleague)... it is a learning opportunity for me so far as my profession is concerned, I have learnt a lot as far as counselling is concerned”. *(Naivasha Health Service Provider)*
c) Health service provider views on training

Health service providers indicated the trainings enabled them become more conversant with their role in delivery of post rape care services to child survivors.

“The training has been good because as it has made me understand my role. I’m now able to give proper referrals because once a case lands in my office I know where I’m supposed to take it next or who I am supposed to go to for further assistance.” (Naivasha Health Service Provider)

For many of the providers, training on management of child survivors was a new concept as it enabled them learn how to correctly fill the PRC form in addition to obtaining a detailed history:

“I am able to understand and to attend to the children and also I’m able to take a very detailed history and also fill the PRC forms.” (Nyeri Health Service Provider)

Health service providers were able to support both children and caregivers and ensure they were comforted:

“...it(training) also assisted me in terms of handling both the survivor and the relatives so initially you know you could find the survivor has come and immediately you are told there is a case of sexual assault you just take the receipt write the investigation. Right now I talk to the child, talk to the mother if she is there and the person who escorted them and you try to create a rapport so that he/ she is comfortable with the environment where I am going to handle them.” (Naivasha Health Service Provider)
As a result of the training, the providers also acquired competency skills that enabled them communicate well with the child survivors

“It (training) was very important because the way a child presents is different from the way an adult would present and again the use of play and art therapy to reveal some of the hidden symptoms was also very helpful in the training.” *(Naivasha Health Service Provider)*

One provider stated that the training helped them improve on their understanding and comprehension of child survivors of sexual violence:

“I have learnt that for you to be able to handle those children, you need to come down to their level. Also issues like therapy; we are doing so well when it comes to those children. So it has become easier for me to handle those children. You understand them so well than it was there before.” *(Nyeri Health Service Provider)*

The national guidelines on management of sexual violence require for health providers to obtain consent from children before providing any service. Providers who participated in this study stated that the training enabled them understand the importance of taking consent from children:

“It (training) was very important because it helped me understand ....that, you must get permission from a child. You need the real details about what happened and in every follow up as they come for counselling you are able to get new information the child continues to adapt...” *(Naivasha Health Service Provider)*
In addition Health service providers learnt how to collect, and importance of maintain a chain of custody:

“Actually it opened my mind that the samples that I receive are very crucial to this client; I need to examine them properly to give enough evidence that actually something happened to these survivors. To preserve the same, the report also it has to be confidential. It is not every person who should be given the results, we have to preserve the results, have a book whereby we register them and also to release them in a confidential manner.”

(Nyeri Health Service Provider)

They also learnt how to package evidence collected from survivors:

“The training has changed me by...It has helped me to collect the forensic evidence. How the client comes to the facility; you take all the clothing, everything, you put in a khaki bag and then you do the rest of the investigations and you keep the specimen in the right place.”

(Nyeri Health Service Provider)

6.3 Demand for the Intervention

This section describes study findings on the demand for the intervention – that is, the extent to which the intervention is likely to be used by child survivors and their caregivers, drawing on service statistics data related to post-rape care during the intervention period (December 2016 to March 2017).

6.3.1 Demand for the intervention by child survivors of sexual violence

Quotes presented previously in this report from child survivors and caregivers suggest that they are highly likely to use the case advocate component of the intervention if made available to them during hospital visits. In addition, case advocates themselves indicated that child survivors were responsive to their follow-up phone calls to remind them of upcoming PRC appointments – another indication of the demand for the case advocate aspect of the intervention:
“...some clients leave the hospital and go to their homes and sometimes they tend to forget so when we call them and tell them they are to come back (to hospital for re-visit) they would come and many of them returned positively” (Naivasha, Case advocate)

Post-rape care services statistics shed further light on the extent to which the intervention is likely to be used by child survivors and caregivers in that they depict actual numbers of survivors receiving such services during the intervention period.

An analysis of children accessing PRC services from November 2016 to March 2017 revealed that 98 children accessed these services in the two facilities.

**Figure 4: Trends in PRC service uptake between November 2016 – March 2017**

The low uptake of services in January can be attributed to absence of case advocates, who were recruited in February 2017. The presence of case advocates in the two facilities resulted in increased uptake of PEP, trauma counselling, HIV testing, and STI treatment. However, these statistics should be interpreted factoring in a strike by health care providers from December 2016- March 2017 which affected use of all health services in Kenya. Most of the providers involved in the direct delivery of HIV testing, ECP and trauma counselling services were affected by the strike.
7 SUMMARY OF KEY MESSAGES

The Intervention aimed to assess the feasibility of enhancing child survivors’ access to comprehensive post-rape care services in two public health facilities. The main intervention components included: recruitment and placement of case advocates; training, continuous mentorship and debriefing sessions for health service providers; development of standard operating procedures on management of SGBV in children; development of caregivers and survivors literacy materials, and setting up of child friendly rooms. Below, we summarize key messages from the study findings:

a) Case advocates promoted child survivors’ access to services:

The introduction of case advocates into the health system proved to be a critical component of the intervention. According to the child survivors and caregivers, it helped improve access to Post Rape Care services as it: i) shortened the length of time it took to receive care by ensuring expedited service delivery, and ii) ensured that there was a liaison between the health system and children and their caregivers. Hence, children were not required to explain the purpose of their visit to every provider. The case advocates’ roles resulted in physical and psychological relief for children and caregivers while accessing services at the health facilities.

Furthermore, providers indicated that the case advocate role supported their own work in the following ways: i) facilitated the identification of survivors, ii) ensured the delivery of samples to the laboratory for analysis, iii) fostered the successful referral of child survivors to different service delivery points; and iv) ensured survivors understood the importance of visiting the different service points.

As a result of the case advocates’ role, an increase in the uptake of essential services (e.g., PEP, trauma counselling, HIV testing, and STI treatment) by child survivors was observed during the intervention period.

b) Provider training and debriefing sessions strengthened the response to child survivors:

The training sessions improved the capacity of health providers to offer PRC services to children. Providers stated that the training enabled them acquire skills required to undertake the following: i) accurately fill in the PRC forms and registers, ii) examine and obtain history from the children, iii) communicate appropriately with the children; iv) obtain consent taking from children; and v) offer comprehensive services to child survivors.

The debriefing sessions, according to health providers, were useful in providing them with a platform to address trauma related to provision of PRC services to children, and an opportunity for cross learning between health service providers.
CONCLUSION AND RECOMMENDATIONS

The study findings point to the feasibility of improving child survivors’ access to comprehensive PRC services through this intervention, as evidenced by the increased uptake of various post-rape care services by child survivors receiving various components of PRC during the intervention implementation period.

Given the prominence of case advocates in promoting child survivors’ access to post-rape care under this multi-pronged intervention, we recommend that modalities for integrating such personnel into public health care facilities in Kenya be devised and implemented. Possibilities for doing so include, having a facility level scheme of service for the case advocate; and establishing ways through which case advocates can be integrated within the health facility support staff structure.

However, children’s access to post-rape care would be incomplete without strengthening the capacity of responders in health facilities to provide appropriate care. The training provided under this intervention would be beneficial in this regard. Furthermore, there is need for effort to be made towards the integration of routine debriefing sessions and continuous mentorship in health facilities offering post-rape care. These services can be offered by facility supervisors at sub-county and county level.
REFERENCE LIST


10 ANNEXES

10.1 Appendix 1: Overview of the Health service providers training

INTRODUCTION

All health providers who play a role in post-rape care for children in each of the two health facilities went through a 5-day training session on general post-rape care, using the MoH curriculum on the clinical management of survivors. Subsequently a 3-day skills and competency-based training on the specialized management of child survivors of sexual violence was also carried out. The training team comprised of experts from LVCT health, Ministry of Health, and the Government Chemist.

Below is a summary of the content covered during the 3 day training:

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
</tr>
</thead>
</table>
| • Introduction to the child management study.  
• Psychosocial support for child survivor of sexual violence. | • Forensic evidence; from crime scene to court  
• Child sexual assault and physical examination | • Survivor referral pathways and follow-up  
• PRC Form: practical session  
• The role of case advocates.  
• Introduction to the session observation tool  
• Action planning |
WORKSHOP LEARNING OUTCOMES

The learning outcomes of the health providers training were:

i. To define competence in provision of various forms of psychosocial support to child survivors of sexual violence with the aim of facilitating their resumption to normalcy and full integration into society.

ii. To describe skills required in physical examination of children.

iii. To describe how to take a focused forensic history, collect, handle, document, store, preserve, and observe the chain of custody.

iv. To describe the role and function of the case advocates in the study.

v. To review the survivors’ referral pathways within and outside the health facility, identify gaps and strategies to overcome them.

vi. To review the post-rape care form and know how to fill it correctly.

vii. To describe the role of the case advocate.

viii. Review the session observation checklist and know how to administer it.
FACILITATION APPROACH

The facilitation team used a mix of participative adult learning methods to stimulate discussion and learning amongst training workshop participants which included:

- Lectures
- Group discussions
- Experience sharing
- Buzzing
- Brainstorming
- Demonstrations
- Practical exercises
- Reflection
- Energizers