STUDY REPORT

Health Facility Responsiveness to the Needs of Child Survivors of Sexual Violence

Case Study of Nyeri and Nakuru Counties, Kenya

MAY 2016

STUDY COLLABORATORS:

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Population Council
www.popcouncil.org

FUNDING SUPPORT

Embassy of Sweden
www.swedenabroad.com

Norwegian Agency for Development Cooperation
www.norad.no/en/

To be cited as:

Ajema, C., Ngunjiri, A., Ouko, J., Karuga, R., and Digolo, L. (May 2016)
Health facility responsiveness to the needs of child survivors of sexual violence:
A case study of Nyeri and Nakuru Counties, Kenya: LVCT Health

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ABBREVIATIONS

CCC	Comprehensive Care Clinic
DHS	Demographic and Health Survey
EC	Emergency Contraception
GBVRC	Gender Based Violence Recovery Centre
GOK	Government of Kenya
Hb	Hemoglobin
HIV	Human Immunodeficiency Virus
HRIO	Health Records Information Officer
OBS/GYN	Obstetrics and Gynaecology
OVC	Orphans and Vulnerable Children
PEP	Post Exposure Prophylaxis
PHO	Public Health Officer
PHR	Physicians for Human Rights
PRC	Post Rape Care
SOA	Sexual Offences Act
SOPS	Standard Operating Procedures
STI	Sexually Transmitted Infection
SV	Sexual Violence
TFSOA	Taskforce on the Implementation of the Sexual Offences Act
VAC	Violence against Children
VDRL	Venereal Disease Research Laboratory test
WHO	World Health Organization

ACKNOWLEDGEMENTS

This study was made possible with financial support from the Regional Team for Sexual and Reproductive Health and Rights (Embassy of Sweden, Lusaka, Zambia), through the Population Council.

The authors appreciate the contributions made by Dr. Chi-Chi Undie and Dr. Harriet Birungi of the Population Council, Nairobi office, during the design of this study.

We appreciate the support received from the County Health Executives of Nakuru (Dr. Mungai Kabii) and Nyeri County - Dr. Peter Munyua and the County Health Management teams. Also acknowledged are Dr. Cyrus Njoroge - Medical Superintendent, Violet Alela - Nursing Officer, Grace Njagi - Nursing Officer from Nyeri County referral hospital and Dr Joseph Mburu - Medical Superintendent, Emily Kiragu - Nursing Officer, Peninah Kimani - Medical Social Worker - all from Naivasha County hospital for supporting the research teams. We also acknowledge their commitment towards strengthening the delivery of child - friendly post-rape care services in their counties and facilities. Appreciation also goes to Caleb Osano, Dr. Cleophas Ondieki and Stella Gitia of LVCT Health for their immense contribution in liaising with the County Health Executives.

We also acknowledge input received from the health management committees on the study tools and recruitment of the study participants. We appreciate the guidance received from the Medical Superintendents and the Departmental heads in permitting the teams to review facility records and also conduct interviews within the hospitals.

Our gratitude also extends to all the study participants, namely, the child survivors and their caregivers, and health care providers who agreed to participate in this study.

We also acknowledge the invaluable contribution of the data collection teams – Lydia Nyaga, Beatrice Kariuki, Charity Mbugua and Martin Odhiambo, and Margaret Kababu, who coordinated the data management processes.

EXECUTIVE SUMMARY

Violence against Children is a serious problem in Kenya. According to the Violence against Children study conducted in Kenya in 2010, about 11% of females and 4% of males aged 13 to 17 experienced some type of sexual violence; while at least 32% and 18% females and males respectively reported experiencing sexual violence during their childhood. The Ministry of Health has developed standards governing delivery of Post Rape Care (PRC) services. However, these services and national guidelines are biased towards management of adults. There also exists no evidence on how service providers in public health facilities manage child survivors of sexual violence. As a result, LVCT Health conducted a formative assessment in 2015, aimed at assessing the quality and comprehensiveness of health related services provided to child survivors of sexual violence in Kenya.

This study utilised an exploratory research design. This study was carried out in 2 county referral hospitals (Naivasha County Hospital and Nyeri County Referral Hospital) from January to July, 2015. Both qualitative and quantitative data collection methods were used: (i) Facility inventories of existing infrastructural and human resource capacity for attending to child survivors of SV; (ii) key informant interviews with 31 providers; (iii) Observations of 19 sessions of child survivors seeking care; (iv) Exit interviews with 14 care givers and child survivors who sought post-rape care services during the study period; and (v) a retrospective health facility review of 164 records maintained for child survivors of rape who had accessed services 6 months prior to the commencement of the study. Purposive sampling was employed to sample providers, survivors and their care givers, and client records. Descriptive analysis of data obtained from the medical record review data was carried out using SPSS, while data obtained through the facility inventory assessments, client exit interviews, and observations was analysed using MS Excel. Key informant interviews with providers were analysed using NVIVO ™ 10 analysis software, with the Framework analytical approach used to identify and code for key emerging themes. Ethical clearance was obtained from the Population Council's Institutional Review Board in New York and from the African Medical Research Foundation (AMREF) Ethics & Scientific Review Committee (ESRC) in Nairobi.

Results:

Service Uptake: While PRC services were noted as being available in the two facilities, not all child survivors were able to access them, either due to the lack of drugs and medical equipment, services not being available on certain days/time, or the lack of trained providers. In one of the facilities, there were no records obtained for child clients who had received counselling.

The utilisation of the national data capture tools: SV documentation by providers is still a big problem and the police medical report form was the least likely to be filled out, despite its importance for judicial outcomes. The low use of the pharmacy register was attributed to the introduction of an Electronic Medical Records system, which is yet to incorporate PRC documents. The incomplete utilisation of the tools also poses a challenge in maintenance of evidence and the chain of custody which is critical for medical and judicial outcomes. These documents are also not securely stored, and can easily be tampered with or lost. The P3 forms are not filled in daily for all survivors, requiring them to make several visits to the hospitals.

Lack of protocols for managing child survivors: Lack of designated service delivery points for child survivors of sexual violence resulted in child survivors queuing alongside other patients before being attended to. Some clients had to wait for 2 hours before receiving services. The study revealed the lack of service delivery charters to guide providers on how to manage paediatric survivors of SV. There lacks counselling and psychosocial assessment protocols for child survivors, and providers are not trained on how on how to undertake this.

No standard referral protocol and tools exists for child survivors which impacts on the quality of care provided. There is a discrepancy in the number of cases of documented in different service delivery documents. This would be attributed to weak referral by providers and uptake by survivors. There were no mechanisms in place to facilitate referral of children abused within their home environment to safe shelters. No follow up mechanisms exist for children upon exiting the health facility to enhance continuity of care.

Provider capacity and attitude: Most of the providers had been sensitised on broader gender based violence, but only 2 out of the 518 providers had been trained on the management of child survivors of SV. A few care givers and survivors cited provider attitude as one of the aspects they disliked. Providers indicated challenges in examining and obtaining history for survivors.

Poor infrastructure: Health facilities do not have most of the equipment required in evidence collection and management of children. In addition, the rooms were not child-friendly as they lacked a waiting bay for care givers and a play area for children. The facilities do not have dedicated storage facilities for evidence and data obtained from child survivors.

Commodity supply: Survivors were required to pay for STI drugs and filling of the P3 form. Stock out of EC was cited as a challenge.

Lack of child and care giver PRC literacy IEC materials: None of the facilities had IEC materials that could be used to sensitize the children and their care givers on the available care and the need for them to access the full package of care. Providers did not have standard checklists to guide them on the information to be shared with survivors and caregivers.

Conclusion

National guidelines on management of sexual violence in Kenya outline the minimum package of care to be provided to survivors of sexual violence, however they do not provide clear standard operating procedures for the management of child survivors. Findings demonstrate that current PRC services are not structured in a manner to facilitate delivery of quality services to child survivors. Health facilities are not adequately equipped with infrastructure and supplies that are friendly to child survivors and their care givers. The capacity of health providers in the management of child survivors is weak due to lack of skill based training on the dynamics of responding to the needs of child survivors. There also lack measures to enhance care giver understanding on the package of care to enable them offer adequate support to their children and enable them access services in a timely manner.

Recommendations

The study recommends the following:

- A minimum package of care for child survivors should be developed to address history taking, examination, evidence collection, counselling for HIV, STI and pregnancy, and follow up care.
- The Ministry of Health should strengthen data management and commodity supply systems within facilities.
- Develop a referral protocol for child survivors accessing care in public health facilities and those referred to safe shelters and other non-health related services.
- Build the capacity providers on the management of child survivors of sexual violence. All service delivery points should have trained providers.
- Health facilities should be adequately stocked with the commodities and supplies required to facilitate comprehensive management of child survivors. Paediatric drugs should be availed to all survivors at no cost.
- Develop national guidance and service delivery protocols on provision of psychosocial support and assessment.
- Where possible, set up child-friendly spaces in facilities to ensure child survivors are attended to in comfort and privacy.

- Care giver literacy materials on the package of care should be developed and utilised by providers to sensitize caregivers on the different components of care available for child survivors of SV. An information checklist should be developed to guide providers on the essential information they should give child survivors and their care givers.

1. BACKGROUND

Child sexual abuse is a critical public health, human rights and developmental issue that has severe consequences for the immediate and long-term health and well-being of children. Public health facilities are in many instances the first point of care for most survivors seeking medical and psychosocial attention. 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 over half of these being of less than 18 years of age (GVRC, 2012). Data generated from 130 public health facilities supported by LVCT Health in Kenya indicate that about 8,500 rape survivors were attended to between 2011 and 2014. Of these, 64 percent were children under 18 years (LVCT Health, 2014). However, the extent to which the public health sector in Kenya is equipped to respond to child survivors' needs in a comprehensive and quality manner is unclear.

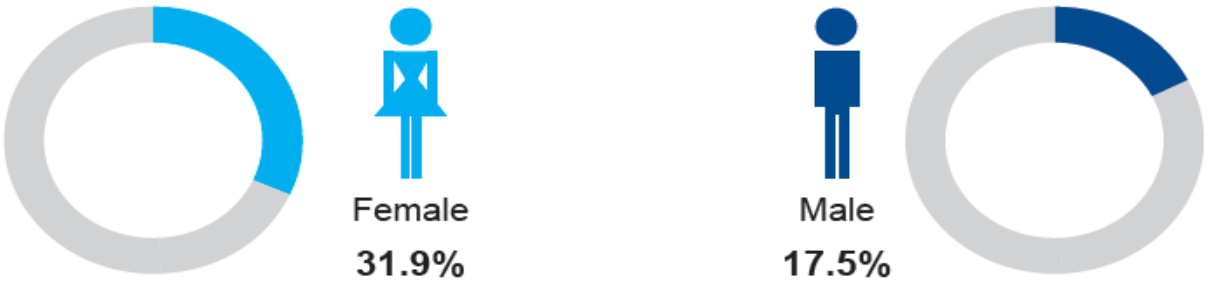
Numerous efforts have been made to strengthen the quality of services offered to survivors of sexual violence in the country. At the global level, the PEPFAR (President's Emergency Plan for AIDS Relief), developed Technical Considerations for the Clinical Management of Children and Adolescents who have Experienced Sexual Violence in health centres (Day & Pierce-Weeks, 2013). The considerations focus on the delivery of PRC in primary health facilities to survivors aged less than 18 years. The focus of the considerations is on the delivery of clinical post-rape 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. So far, only 2 countries (Mozambique and Lesotho) have undertaken desk reviews towards adaption of these considerations. The Lesotho desk review revealed a lack of comprehensive guidelines, protocols, and services available to respond to the Unique Needs of Child Survivors of Sexual Violence and Exploitation, while the Mozambique review revealed insufficient capacity (financial and human resource) to provide services towards survivors' physical, psychological, and social needs (Rock, 2013; Weber, 2013). The two reviews further recommended the need to pilot PEPFAR's technical considerations for clinical post-rape care for children and the development of clinical and community-based protocols on post-rape care, including GBV screening for children, and referrals to legal and psychosocial services. In Kenya, the Ministry of Health has developed national guidelines, standard operating procedures, and a training curriculum on the management of survivors of sexual violence. According to the national 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; counselling for trauma and referral for the on-going well-being for survivors (MOPHS & MMS, 2012).

Research demonstrates that a significant proportion of child survivors rarely benefit from available health services. This could be due to failure by children to disclose abuse. While disclosure of abuse is necessary for provision of services, it is not sufficient in itself if no efforts are made to facilitate the provision of quality, child friendly and responsive services that are not only affordable, but easy to access by all. A study undertaken in South Africa revealed that even in instances where children presented to hospitals following sexual violence, 65% of them did not benefit from a full course of post exposure prophylaxis, 51% did not receive any counselling, and 45% did not have their cases forwarded to the criminal justice system.

1.1 Extent of the problem in Kenya

Violence against Children (VAC) is a serious problem in Kenya (Keesbury & Askew, 2010). According to the Kenya VAC study (UNICEF, 2012), about 11% of females and 4% of males aged 13 to 17 experienced some type of sexual violence. A study on violence against children that was carried out in seven countries showed that in Kenya, at least 32 percent of females and 18 percent of males reported experiencing sexual violence during their childhood (UNICEF, CDC, & KNBS, 2012).

Figure 1: Experience of SV before attaining 18 years (VAC, 2010)



Highlights

- 3 out of every 10 females and nearly 2 out of every ten males aged 18-24 reported at least one experience or sexual violence prior to age 18.
- Of females whose first sex occurred before age 18,24 reported it was unwilling, meaning that they did not want it to happen and were forced, pressured, tricked or threatened to engage in sexual intercourse.
- In the 12 months prior to the survey, about 11% of females and 4% of males aged 13-17 years experienced some type of sexual violence VAC, 2010.

1.2 Current response to survivors of sexual violence in Kenya

The Ministry of Health has put in place National Guidelines on the Medical Management of Survivors of Sexual Violence. According to these guidelines, survivors are to receive services related to medical examination, pregnancy prevention/and or management, HIV diagnostic testing and counselling, Post-Exposure Prophylaxis (PEP) and or referral for HIV care, management of sexually transmitted infections, Evaluation and treatment of injuries, forensic examination, evidence collection and documentation, and long-term psychosocial counselling and rehabilitation. The guidelines do not however stipulate in depth how the above services should be provided across the health sector to children. Furthermore, there lacks comprehensive accurate data regarding accessibility of these services by child survivors, attitudes and capacities of providers engaged in managing child survivors, and infrastructural support available in health facilities for history taking, evidence collection, preservation and analysis, and referrals.

2. GOAL AND OBJECTIVES OF THE STUDY

This study was carried out to help establish the extent to which the public health system is equipped and prepared to respond to the health needs of child survivors of sexual abuse in Kenya. The overall goal of the study was to assess the quality and comprehensiveness of post-rape care services provided to child survivors of sexual violence in Kenyan public health facilities.

The study's specific objectives were to:

1. Document services offered to child survivors of sexual violence in public health facilities in Kenya.
2. Assess the capacity of public health facilities to deliver health services to child survivors of sexual abuse.
3. Assess the quality of care offered to child survivors of sexual violence in health facilities in the country.
4. Identify possible ways of improving the availability and quality of services offered to child survivors of sexual violence in the country.

3. STUDY DESIGN AND METHODOLOGY

This section presents the methodological approach to the study, elaborating on the specific study methods, sampling procedures, data collection procedures, study tools that were used, and data analysis procedures.

3.1 Study Design

This study used an exploratory research design, drawing on situation analysis approaches for assessing reproductive health services (Miller et al., 1997). A mix of quantitative (involving the use of structured questionnaires) and qualitative (involving key informant interviews) data collection methods were applied in this study.

3.2 Study sites

The study was carried out in 2 health facilities that offer PRC services; Naivasha County Hospital (Nakuru County) and Nyeri County Referral Hospital (Nyeri County). Purposive sampling was used in selecting these 2 county referral hospitals based on the fact that LVCT Health works closely with them; both hospitals have providers trained by LVCT Health on the management of sexual violence survivors; they both receive the greatest number of survivors per month compared to other health facilities associated with LVCT Health; and they are both located in relatively close proximity to LVCT Health's head office in Nairobi.

The Naivasha County Hospital is located in a cosmopolitan region. PRC services started being offered in the facility in 2005. The facility records approximately 40 survivors of sexual violence per month, with the majority being children. PRC services are offered across delivery points located in different units in the facility. The Nyeri County Referral Hospital is also located in a cosmopolitan area. The facility has a Gender Based Violence Recovery Centre (GBVRC) that was commissioned in 2013. Dedicated PRC services (with the exception of pharmaceutical services) are offered in one room. The facility records approximately 15 survivors per month.

3.3 Study population

This included child survivors of violence, care givers of such survivors, and health care providers.

3.4 Sampling methods

The approach taken in determining the various study units is elaborated below.

3.4.1 Sampling of Survivors and Caregivers

Child survivors and care givers who presented at the hospital for PRC services during the study implementation period (January to June, 2015) were recruited into the study. To identify survivors and their caregivers at both hospitals, the research team relied on triage nurses located at the

outpatient department whose daily responsibilities include assigning inpatient and outpatient numbers for all patients presenting for care, in addition to identifying reported cases of SV. The research team was introduced to every child who presented for care along with their caregiver. However, only those children and caregivers who consented were included in the study. In certain instances where the child was not comfortable with participating, we recruited the care giver alone. Children who were interested in study participation were only enrolled in the study if their caregiver gave consent for such participation. In total 19 children and their givers participated in the study.

3.4.2 Sampling of providers

Service providers were purposively selected to include those whose daily responsibilities include managing survivors of sexual violence. The providers sampled included doctors, nurses, clinicians, social workers, pharmacists and laboratory technologists. Two providers were sampled from each service delivery point, namely, casualty, laboratory, wards, comprehensive care clinics, pharmacy, and, counselling departments.

3.4.3 Sampling of records

All medical records / charts of child survivors aged 18 years and below and who had received PRC services 6 months prior to the commencement of the study were reviewed. The records reviewed included the national data collection tools and registers maintained by the Pharmacy, laboratory, and trauma counselling and outpatient departments. These included the national PRC form and registers. The PRC form is an examination documentation form for survivors of rape/sexual assault. Health care providers are required to complete the PRC forms to record the survivor's examination details and the results of any laboratory analysis carried out. The form is usually produced in triplicate: 1) the original white copy of the PRC form, alongside the Kenya Police medical examination form (also known as the 'P3' form), constitutes part of the police records; 2) the duplicate green copy of the PRC form is given to the survivor; 3) the yellow copy is retained in health facility records. The PRC forms capture the survivor's name, date and time of presentation, age, sex, date and time of assault, physical examination taken and samples collected for analysis.

3.5 Data collection

3.5.1 Health facility inventory

A facility inventory was undertaken by the use of a structured questionnaire administered to one provider per facility. The researcher visited each of the service delivery points accompanied by the nurse in charge (or a representative). The questionnaire was intended to generate information on service delivery points where PRC services are offered, providers who offer these services, PRC services provided, available equipment for management of survivors of SV, documents used and referral pathways for survivors of SV.

3.5.2 Medical Records for child survivors of SV

The records of child survivors of rape (ages 18 and below) who had accessed PRC services from January to June, 2015 were reviewed at each hospital. Service statistics were abstracted to determine trends in client age, gender, time of assault, time of presentation at service points, services accessed, number receiving and completing comprehensive services, and referrals within and beyond the study sites, in addition to establishing level of utilization of the data tools and registers in documenting information received from survivors and services offered. An MS-Word data capture tool was developed and utilized for data collection. Survivor and caregiver exit interviews and observed sessions.

Structured observations were carried out to gain an understanding of the type of services received by child survivors, average client waiting times at the different service delivery points, referral flow within the system, and exit points from the health care system. Client exit interviews sought to assess the satisfaction of child survivors and caregivers with the post-rape care services accessed.

Perspectives of providers on managing survivors aged below 18 years were obtained through the use of a key informant interview guide developed by the research team. The interviews sought to establish respondents' knowledge of PRC service delivery; attitudes towards managing child survivors; training needs as well as utilization of national protocols during service delivery. These interviews were conducted at the facility.

4. DATA PROCESSING AND ANALYSIS

4.1 Data analysis

All questionnaires were assigned a study code as a measure of safeguarding the participants' confidentiality.

Descriptive analysis of data obtained from the medical record review data was carried out using SPSS, while data obtained through the facility inventory assessments, client exit interviews, and observation was entered into Excel and then analysed manually. Missing data from the various medical records was omitted from the analysis.

Audio recordings from the provider interviews were transcribed in MS Word, coded and analysed in themes using NVIVO ™ 10 analysis software. The Framework analytical approach was used to identify and code for key emerging themes.

5 ETHICAL CONSIDERATIONS

Ethical clearance for this project was obtained from the Population Council's Institutional Review Board in New York and African Medical Research Foundation (AMREF) Ethics and Scientific Review Committee (ESRC) in Nairobi.

The following WHO guidelines on researching violence were observed under the project:

- Information gathering and documentation was carried out in a manner that presented the least risk to the respondents. For example, to minimize risks to participants, researchers did not sit in during the survivors' actual consultations with providers.
- Survivors were interviewed only after they had accessed basic care and support.
- The confidentiality of data obtained was preserved by using study codes for respondents' data records. The observation forms had no identifiers on them, apart from the name of the hospital in which it was being conducted. Only investigators and project staff had access to the study information.
- Informed consent was obtained from all respondents and health facility management before participating in the study. Researchers were introduced to survivors and care givers by trauma counsellors. Those willing to participate were requested to sign the informed consent forms. A thumb-print section was availed to those who didn't know how to write. Respondents were informed of their right to withdraw from the study at any time or not to answer any questions they felt uncomfortable with. Informed assent was obtained from child survivors before they were enrolled into this study.
- Training of the research team supporting in data collection and record review was undertaken prior to the commencement of the study. Key ethical issues in research involving children were a focus of the training.

6. FINDINGS

The study findings are presented in the following order:

- Facility inventory.
- Medical records review.
- Survivor and care giver exit interviews and observations.
- Health provider key informant interviews.

6.1 HEALTH FACILITY INVENTORY FINDINGS

This section highlights findings obtained from an inventory of the two facilities highlighting service delivery timings, PRC services available for child survivors, available equipment, staff availability and capacity, national documents in use during management for child survivors, and referral protocols in place.

6.1.1 Timing during which PRC services are provided within the facility

Both facilities offer 24-hour PRC services to child survivors. However, these services are offered at different service delivery points depending on the time at which the survivor reports to the hospital. In both facilities, survivors who report before 8 am and after 5 pm receive general care at the casualty department alongside other general patients. One of the facilities has a "one-stop gender based recovery centre" (GBVRC) , but not all services are provided within this wing. In addition, this centre does not operate 24 hours a day, 7 days a week. Survivors are only attended to at the GBVRC if they present between 8 am and 5 pm. In the other facility, survivors who report between 8 am and 5 pm receive generalised health care at outpatient department before being referred for PRC dedicated services, namely trauma counselling, evidence collection and analysis. As a result, clients are referred to other service delivery points when they present for care after 5 pm and on weekends.

6.1.2 Staff providing PRC services

At the time of the study, a total of 581 providers were found to be working at the two facilities combined.

Table 1: Number of health providers working at facility

	Paediatrician	Obs/gym	Medical officer	clinical officer	Nurse	Trauma counsellor	HIV counsellor	Social worker	Pharmacist	Anaesthetist	Radiographer	Lab Tech	HRIOs	Support staff	Nutritionists	Public health officer
Nyeri	2	2	19	25	238	2	13	3	9	6	7	19	5	23	2	2
Naivasha	1	1	10	13	135	4	3	2	6	4	4	11	3	4	3	-
Total	3	3	29	38	373	6	16	5	15	10	11	30	8	27	5	2

Only 9% (n=52) of staff had undergone formal training on the management of survivors of sexual violence. Majority (30) of the trained staff were nurses. Further analysis revealed that only 2 providers (1 nurse and 1 clinical officer) had been trained on management of child and adolescent survivors of sexual violence.

6.1.3 PRC Services Available to child survivors

The following services were found to be offered to child survivors in the two facilities.

See Figure 2 below.

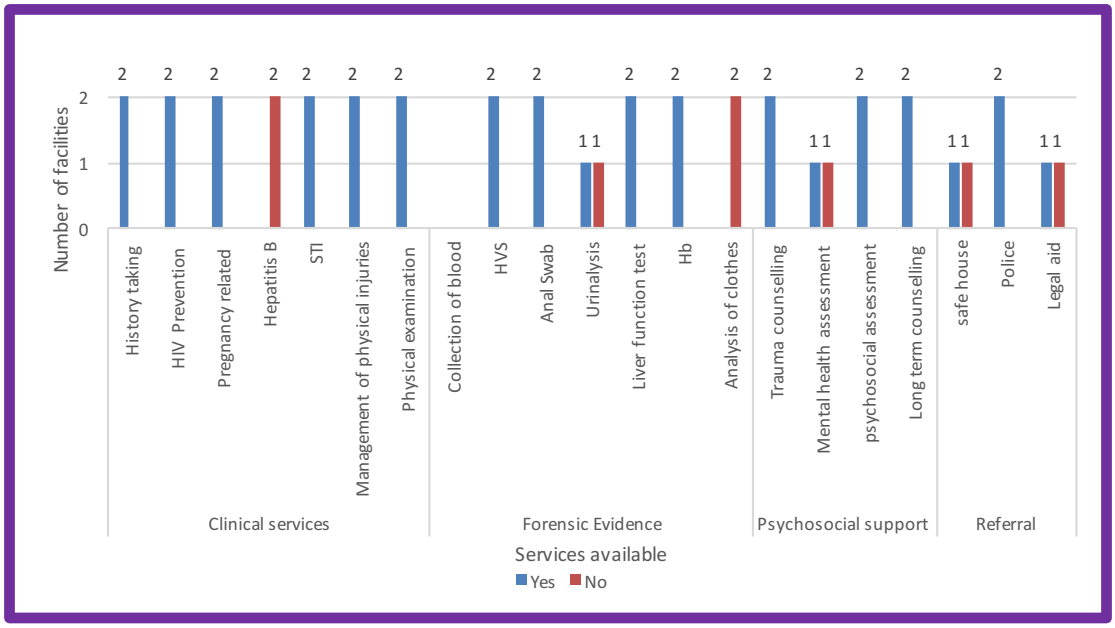


Figure 2: PRC services available for survivors <18 years

None of the survivors was documented to have received the initial Hepatitis B vaccination (the initial injection followed by two further injections at days 7 and 21). Both facilities did not undertake forensic analysis of clothes worn by child survivors during the assault. In one of the facilities, urinalysis, mental health assessment, referrals to safe houses, and for legal aid, and analysis of clothing did not feature strongly as services offered to child survivors.

6.1.4 Child friendly service delivery infrastructure

We sought to establish the existence of certain amenities that are essential in the management of child survivors of sexual violence, according to PEPFAR's technical considerations. The audit revealed that none of the facilities had clear signage directing clients to the different places where they can access PRC services within the hospital. In addition, none of the facilities had a designated waiting area for care givers to use while their children were being attended to. Not all of the rooms were secured to ensure privacy during care. In one of the facilities, clients could be seen from outside by other patients. Direct observation of the toilets in both facilities revealed lack of toilets specifically for children and poor state of those currently being used.

In addition, none of the facilities had a children's play area or a waiting room for admission into the wards, where necessary. All the IEC materials that were displayed at the GBVRC were only focussed on adults, while the youth friendly centre in one of the facilities only had a pool table for use by youth visiting the centre. There also lacked any materials highlighting the package of care that was to be offered to paediatric survivors.

Figure 3: Examination area

Figure 4: Waiting Bay

Figure 5: Toilet Facilities

6.1.5 Availability of equipment for managing child survivors

The study also sought to find out if the kind of equipment available at the hospitals was adequate to provide comprehensive services to child survivors, with a focus on examination and evidence collection at service delivery points where paediatric survivors received care.

Table 2: Availability of equipment

Presence of	Num ber of facilities (n=2)	
	Facility A	Facility B
Examination table	√	√
Adequate lighting	√	√
Working angle lamp	√	X
Paediatric speculum	X	X
Powder free gloves	√	√
Hand held magnifying glass	X	X
Sharps containers	√	√
Swabs	√	√
Lockable medical supplies cabinet	√	√
Blood collection tubes	√	√
Pregnancy test kits	√	√
STI drugs	√	√
Antiemetic's	√	√
Lockable cupboard for forensic evidence	X	X
Gowns for paediatrics	√	X
Sanitary towels	√	X
Changeover of clothes	√	X
Digital camera	X	X
Glass slides for specimens	√	√
Playing materials	X	X
Emergency contraceptives	√	X
Analgesia	√	√
Tranquilizers	√	X
Pre-packed evidence collection kit	X	X

Figure 6: Available equipment

As can be seen in Table 1 the two facilities had the essential equipment to offer care to child and adolescent survivors. However, none of them had a paediatric speculum, pre-packed evidence collection kits, lockable cupboard for forensic evidence. Some of the above equipment was only available in certain departments within the hospital. This means that certain pieces of evidence are either not retrieved from survivors or survivors have to move across different departments increasing the likelihood of evidence contamination and loss.

6.1.6 Availability of national documentation tools

The National Guidelines on the management of sexual violence require health care providers to accurately document history obtained from survivors, investigations undertaken, results of the analysis, referrals made. It was established that in the two facilities visited, providers were using documents stipulated within the national guidelines. These documents include the PRC form, registers, and consent and assent forms. However, the two facilities did not have consent and assent forms, which are essential before any service is offered to a survivor aged below 18 years.

6.1.7 Referral processes for survivors

While it was established that survivors are attended to from different service delivery points, none of the facilities had clear protocols in place for referrals within the hospital and to the other non-health related services. The study established that in some instances, verbal referrals are given to the survivors, or providers accompany them to the next service delivery point. In other instances, the police are called in when a SV related case is reported at the hospital.

6.2 MEDICAL RECORDS REVIEW FINDINGS

This section highlights the level of utilisation and completion of the PRC form and related registers in the management of child and adolescent survivors.

6.2.1 Utilisation of PRC form, registers and P3 form for child survivors

The Kenyan national guidelines on the management of sexual violence stipulate that information about survivors should be recorded in four key documents, namely, the laboratory register, trauma forms, P3 and PRC records. The highest proportion of forms indicated as completed for the survivor was the PRC forms at 87%, whereas the lowest was the P3 form (7.5%). (See table 3).

Table 3: Documentation of survivors accessing services

Source Documents	Total
PRC form	136 (87.2%, *n*=156)
SGBV register	99 (68.8%, *n*=144)
Laboratory register	92 (59.0%, *n*=156)
Trauma Counselling form	46 (57%, *n*=81)
Pharmacy register	48 (43.6%, *n*=110)
Police 3 Form	9 (7.5%, *n*=120)

6.2.2 Level of completion of the PRC form

a) Survivor demographics

A total of 164 medical records (which included PRC forms) of child SV survivors who presented at the two County referral hospitals – Facility A (n=80, 49%) and Facility B (n=84, 51%) – from January to June 2015, were reviewed.

b) Gender and age

Twenty eight percent of the forms reviewed (46, n=164) did not have the gender of the survivors indicated. Similar to findings from other studies, majority of the SV survivors were female, (93%).

The age of the survivor was indicated in 70% of the PRC forms reviewed (115, n=164). The biggest proportion of SV survivors was those between the ages 15 – 17 years at 38% followed by children in the 10-14 and 5-9 age categories, at 34% and 22%, respectively.

c) Names captured on PRC forms

According to the guidelines for completing a PRC form, providers are required to capture three (3) names from each survivor. However, only 81 % (133, n=164) PRC forms reviewed had survivors names captured, with 19% (31, n=164) having only documented two names.

d) Documentation of disability and OVC Status

Only 4.3% (7, n=164) of the PRC forms reviewed had the disability indicated for SV survivors seen at both sites. Eighty three percent (136, n=164) of the forms indicated the OVC status of the SV survivor of which 43% of them were orphaned.

e) Existing Pregnancies documented

Forty one percent (67, n=164) of the forms had the SV survivor's pregnancy status indicated on them. 16% (26, n=164) of the SV survivors were documented as being pregnant. It was not possible to establish whether the pregnancy was due to rape.

f) Referrals to other services

On the PRC forms, 89% of the referrals were to the Police Station. More than half the survivors were referred to the other services – Trauma counselling (74%), HIV Test (73%), Laboratory (71%), and Legal (63%). While majority of the survivors were documented to have been defiled by persons well known and close to them, including relatives, only 7% (11, n=164) of referrals were made to the safe shelter.

6.2.3 Utilisation of the PRC registers

The PRC register provides a summary of the services received by survivors. Over 38% (62, n=164) of child survivors of SV did not present at the health facility for medical attention within the time stipulated in the national guidelines on management of survivors of SV. Sixty one percent (100, n=164) of the SV survivors had both the date of medical examination and date of alleged assault recorded on their register. Of these, 88% reported at the health facility for medical examination with the perpetrator known to them, a proportion of 42% being those who did not report within 72 hours (Table 4).

Table 4: Time within which survivors presented for care

Time of Survivor's Presentation	Knowledge of perpetrator		Total
	Known	Unknown	
<72 hours	51(58.0%)	11(91.7%)	62(62.0%)
>72 hours	37(42.0%)	1(8.3%)	38(38.0%)
Total	**88(100.0%)**	**12(100.0%)**	**100(100.0%)**

Eighty three percent (n=136) records indicated that the incident had been reported to the police. Sixty Eight percent (68%) of the survivors also made the report within 72 hours of the assault). Fifty nine percent (59%) of the forms did not indicate the date the assault was reported to the police.

6.2.4 Provision of prophylactic services

The prophylactic services provided at both health facilities include HIV post exposure prophylaxis, emergency contraceptive pills and sexually transmitted Infection treatment. An analysis of prophylactic services provided to survivors was undertaken through a review of the PRC registers.

a) Received Post Exposure Prophylaxis (PEP)

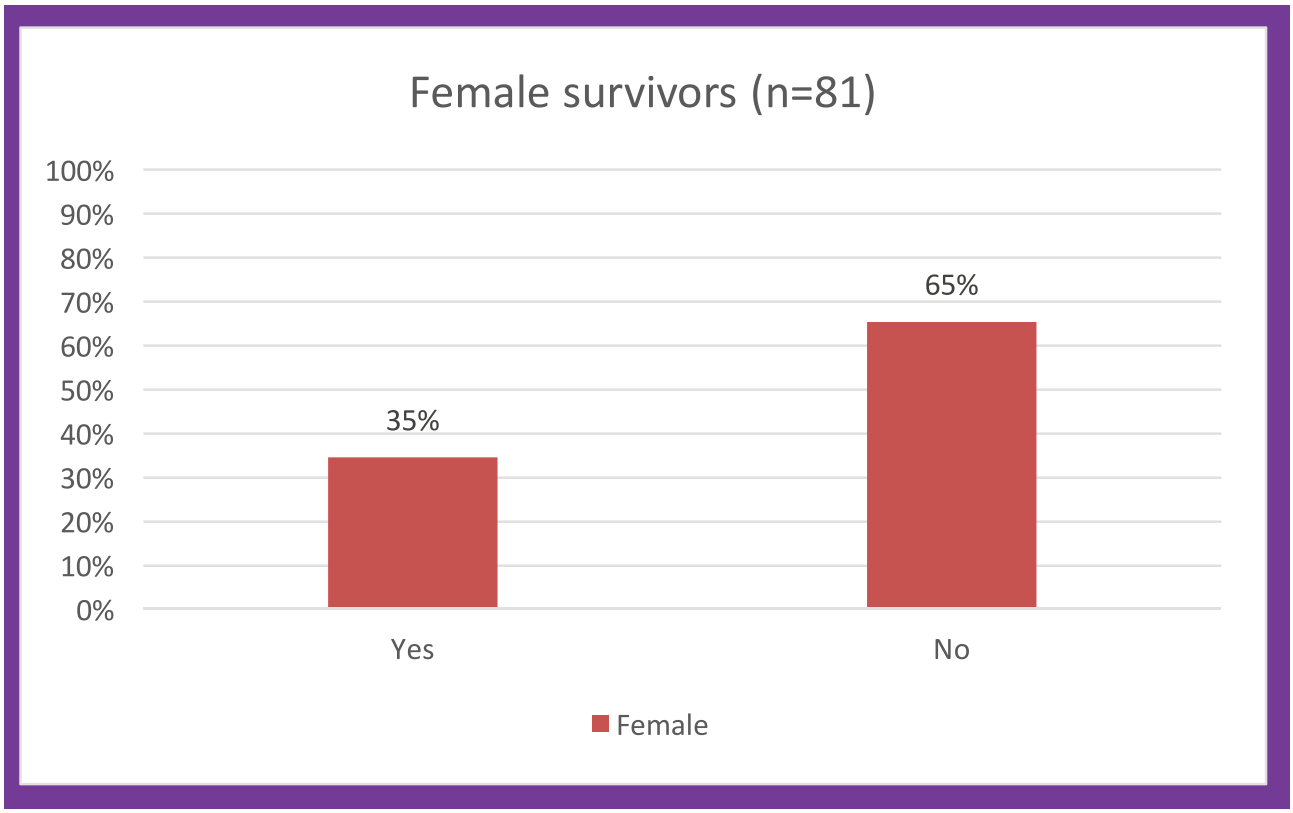
Forty six percent (75, n=164) of child SV survivor records as documented in the PRC registers did not receive PEP despite reporting to the health facility within 72 hours. Furthermore, a quarter of child SV survivors received PEP despite reporting to the hospital beyond the 72 hours period in which it is supposed to be administered for maximum efficacy.

Of the female child SV survivors (n=82), who presented at the medical facility, slightly more than half – 54.9% (45) –received the 1st dose of PEP, with the rest not being given PEP at all. According to the pharmacy records, only 75% (47, n=63) of the survivors received PEP from the pharmacy.

b) Emergency contraception provided

Only 35% (28, n=81) of the female child survivors had been given emergency contraceptive pills. Figure 7. This could be attributed to various factors- young age, lack of guidelines to providers on administering EC to children, and/or late reporting to health facilities.

Figure 7: Female child survivors who received EC



c) STI treatment provided

Eighty percent (84, n=105) of the SV child survivors had received treatment for sexually transmitted diseases during their presentation at the health facility. It was not possible to determine the type of STIs they were treated for as all survivors of SV receive STI syndromic management which includes antibiotics to treat gonorrhoea, chlamydial infection and syphilis.

6.2.5 Collection of forensic samples and chain of evidence

According to the Kenya National Guidelines of the Management of Sexual Violence (1), health care providers are required to collect two types of evidence: evidence to prove sexual assault occurred and evidence to link the alleged assailant to the assault. This section of the report therefore explores samples that were obtained from survivors, and level of utilization of documentation as part of chain of custody of evidence and documented in the PRC form and register.

a) Forensic samples obtained and documented

Various registers were reviewed as part of the clinical record review process – haematology, serology and urine analysis registers.

Records indicated a majority of child survivors had their blood (89.4%), urine (83.7%) and high vaginal swab (77.0%) samples taken. Hardly any pubic hair, nail clippings and foreign body samples were collected from child survivors. This accounted for less than 1% of the SV survivors.

Various tests were conducted (Table 5) Majority of the child survivors had the HIV test (93.4%) and the microscopic test (87.6%) carried out. However, none of the entries in the register indicated the name and signature of the laboratory technician who conducted the analysis. In addition none of results for the forensic samples obtained were documented on the PRC form.

Table 5: Laboratory tests conducted

Laboratory Test	Proportion of results documented
HIV Test	114 (93.4%, *n*=121)
Hb Test	34 (37.8%, *n*=70)
Pregnancy Test	54 (47.8%, *n*=113)
VDRL Test	78 (65.0%, *n*=120)
Microscopic Test	99 (87.6%, *n*=113)

b) Chain of Custody of evidence and documentation

Presentation of health facility medico-legal documentation as evidence at police stations is a critical step in the chain of custody of evidence. The evidence collected at the health facility should be entered into the police files and can be used for prosecution. Part of the evidence chain process is dating and signing of the evidence by the person who collected it from either the health facility or police. Without this signature, the evidence would be inadmissible in court. On the PRC form, there is provision for the police who was issued with the collected sample, and the medical / clinical / nursing officer handing over the evidence to sign and indicate the dates of collection and handing over.

As Table 5 demonstrates, majority (78.4%, n=125) of the SV survivors had their PRC forms signed off by the examining medical or nursing officer as required. However, in both sites, there were barely any forms that had evidence of police receiving the evidence collected by health providers by signing off on the PRC forms as stipulated within the national guidelines.

Table 6: Paper trail of evidence

Chain of custody/Paper trail	Total
Examining Med Officer Sign Off	98 (78.4%, *n*=125)
Police Officer Sign Off	2 (1.5%, *n*=132)
Medical Officer Hand Over of evidence	3 (75.0%, *n*=4)

6.2.6 Provision of psychosocial services

Out of a total of 155 (n=164) survivors documented in the registers as having been counselled, only 46 (n=155) had their details filled in the national trauma counselling form forms were available for review. One form did not have any name indicated on it. Further analysis revealed that 16% of the trauma forms did not indicate the age of the survivor. Only 2 of the 46 forms mentioned the type of SV offence that was reported. In addition, none of the survivors indicated having reported the offence to the police. Only 36% (n=46) indicated having disclosed the assault and received counselling on how to disclose, while 0% of the register entries indicated survivors having been counselled for HIV and disclosed to other family members apart from the care giver who accompanied them to the hospital.

6.3 CLIENT OBSERVATION FINDINGS

This section highlights findings from the client observations and exit interviews carried out to determine survivors' level of satisfaction with services received. The structured observations were carried out to gain understanding of the type of services received by the child survivor, average client waiting times at the different service delivery points, referral flows within the system, and exit points from the health care system. The client exit interviews sought to assess the satisfaction of child survivors and caregivers with the post-rape care services accessed.

6.3.1 Movement of survivors within health facilities

Depending on the severity of the sexual violence case, child survivors were found to move between 6 different service delivery points, namely, triage, outpatient, counselling, laboratory, pharmacy, and wards. However, there was no standard referral pathway for the survivors within and outside the two facilities. Worth noting is that some survivors visited the facility more than once (Annex 1) before receiving the minimum package of care stipulated in the national guidelines.

6.3.2 Waiting time before receiving services

Waiting times at various service delivery points varied significantly. Worth noting is that most survivors spent more waiting time at the outpatient/examination and counselling rooms, than they spent at the laboratory . Data also shows that one survivor who returned to the facility for follow up

care had to wait for more than 2 hours at provider's room before being referred to the laboratory for further examination.

Majority of the survivors spent more than one hour within the facility before receiving care (Table 6). Two of the survivors had to come back for follow up care, while one was admitted due to the injuries she had sustained.

Table 7: Time spent in facility

Patient	Time Spent
Patient 1	2hr 10min
Patient 2	1hr 10min
Patient 3	2hrs 24min
Patient 4	2hr 45 min
Patient 5	1hr 36 min
Patient 6	29min
Patient 7	1hr
Patient 8	4hrs
Patient 9	1hr 29min
Patient 10	2hrs 9min
Patient 11	1hr 27 min
Patient 12	1hr 53min
Patient 13	3hr 33min
Patient 14	2hrs 56min
Patient 15	2hrs 26min
Patient 16	3hr 33min
Patient 17	2hrs 35min
Patient 18	1hr 50min
Patient 19	3 hours

6.4 CLIENT SATISFACTION FINDINGS

This section provides an overview of services received, information given by provider, and medication given, and satisfaction with the services.

6.4.1 Services received by child survivors

Laboratory services were received by most (9 out of 19) of the survivors. The other services received by survivors include injury management (by 1 out of 19 survivors), HIV testing, and filling in of

PRC form (by 3 out of 19 survivors), filling of P3 form (by 2 out of 19 survivors). Eight out of the fourteen did not receive counselling. Evident from the exit interviews was that survivors did not receive the minimum package of care which is inclusive of drugs, laboratory services, counselling and documentation. Only 1 survivor indicated having been issued with a filled in P3 form.

6.4.2 Information received by survivors on the package of care

Eight out of nineteen survivors and their care givers were given information on procedures for reporting to the police; Six out of nineteen got information on the possibilities of HIV infection after a sexual violation; one out of 8 female child survivors received information on pregnancy; five out of fourteen did not receive information on the medication they had been given; only two of the survivors received information on P3 form; while seven of them received information on STIs. Providers did not have a checklist to guide them on the information they are they are to provide to child survivors and their care givers.

6.4.3 Medication received by survivors

Pain killers were the most given type of medication (received by 9 out of 19 survivors) followed by STI drugs (received by 8 out of 19 survivors) and tetanus toxoid (received by 3 out of 19 survivors).

6.4.4 Level of satisfaction with services received

When queried about the services that they liked best, 4 caregivers mentioned laboratory services as the most liked service, followed by the examination by doctors/clinicians (2 care givers). Care givers stated, “The service is good because they serve you”; “The service is good because they serve you well. Every place I visited was good as the providers received us well and have given us the laboratory results when we came to collect”; and also, “Being explained for [being given information] on drugs’ side effect management.”

The survivors liked the services offered at the youth friendly facilities and the assistance offered during the filling of the PRC form. They noted that the wards were clean and appreciated the attention the doctors and nurses paid them when explaining things to them without rushing, and that the doctors and nurses were friendly, concerned and very motherly.

6.4.5 Dissatisfaction with services received

Caregivers mentioned the waiting time for services as the most disliked at 40.0% (n=2), followed by the attitude of clinicians, laboratory services and advice to report to police all at 20.0% (n=1). According to the care givers, they disliked “being advised on reporting to police and she had decided not to report since the perpetrator is a neighbour”, “that providers are slow as one has to wait more than an hour at every point”. One of the care givers indicated dissatisfaction with the way her child was given a referral to a facility which was approximately 32km away before being initiated on emergency care.

> ***"Also the clinician attending threw the documents at us telling us to go to that facility"***
>
> **Care giver.**

The services most disliked by the survivors included the attitude of the clinicians (n=2), the waiting time before being attended to (n=1) and frequently being asked to narrate the ordeal at different service delivery points (n=1).

According to the survivors, "some doctors are not friendly", "the waiting time before being served is quite lengthy as the doctors and nurses took long before attending to me". One survivors indicated dissatisfaction in being asked to "go back (home) and come with my parent/guardian before receiving any kind of treatment." While another cited dissatisfaction in "being asked about what happened in all the departments/place that I was referred to."

6.4.6 Suggested ways of improving PRC services

When asked for suggestions on how to improve the PRC services, two caregivers felt that having a separate room for children to play and having toys to play with would help make the services more child friendly. While other care givers recommended having laboratory services availed during weekends and perpetrators to be arrested.

Survivors on the other hand suggested the need for separate rooms for attending to children (1), friendly doctors (1), creation of counselling groups (1) and being treated first before referral to any other place (1) as suggestions for improving PRC services. One survivor stated the need for "having groups for child survivors from where can get help counselling in to the violence we have undergone."

6.5 HEALTH CARE PROVIDER RELATED FINDINGS

6.5.1 Cadre of the respondents

31 Health Care Providers (HCP) drawn from 2 County referral hospitals were interviewed; 20 of them being female. Providers were drawn from different cadres as indicated in the Table 8 below.

Table 8: Providers by cadre and facility

	Designation							Total
	Adherence counsellor	Clinical officer	Lab Tech	Medical officer	Nurse	Pharmacist	Social Worker	
Facility A	1	3	2	0	3	3	1	13
Facility B	1	2	3	2	6	3	1	18
Total	**1**	**5**	**5**	**2**	**10**	**6**	**2**	**31**

Further analysis revealed that 13 providers (41.9%) had worked for between 1- 5 years. Respondents were drawn from different departments in the health facilities. The pharmacy and the OPD/Casualty had the most number of respondents at 19% (n=6) for both of them. On the other hand, the GBVRC (Gender based Violence Recovery Centre), MCH (Mother and Child Health) and Counselling departments recorded the least number of respondents at 3% (n=1). The distribution of the respondents among the different departments is as illustrated in Figure 8 below.

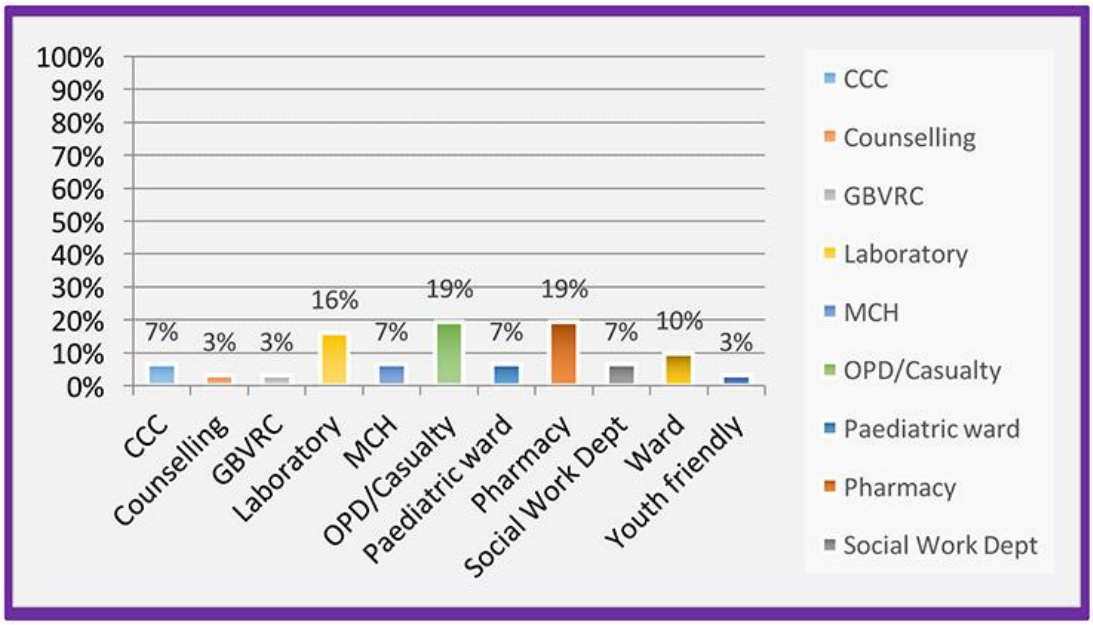


Figure 8: Providers interviewed by service delivery point

6.5.2 Provider consideration in the management of children

Many respondents reported that child survivors require specialized type of care in comparison to the adult survivors. The variation in care, in the opinion of the health care providers, is informed by the level of trauma survivors under 18 years will present with at the facility, the approach to be used by providers in obtaining history and details of the violation, the equipment required to retrieve evidence, and the safety of the children after they have been attended to at the facility. One of the respondents had the following to say regarding the management of child survivors:

> *"…. when we receive these children, they are really traumatized and sometimes the child is not even able to speak for him or herself the guardian is the one who will speak. They are too afraid to even talk. There is a difference {with adults} because sometimes getting the right information from a child becomes a challenge unlike the adult where the adult will give information freely"*
>
> **Nurse, Outpatient Department**

In one facility, a provider mentioned that when a physical examination is to be carried out, most children will not comprehend the procedure and some may be uncomfortable depending on what they had gone through.

> *"Mostly you know when you are examining these children, some of them don't know what you are up to especially a two year old will not know what you are up to. If it was a man who defiled them for example and this is other man {health care provider} who wants to expose the genitals again so she is not comfortable, uncooperativeness sets in"* **Male, Clinical Officer**

Respondents also cited the difficulty in obtaining high vaginal swabs due to lack of equipment such as the paediatric speculum or due to the discomfort displayed by children when they are exposed for a genital exam.

With regards to provision of psychosocial support to child survivors of SV. Few of the providers acknowledged difficulties faced in counselling children due to their limited awareness levels and the questions survivor may be asking themselves.

> *"Counselling a child may be tricky and tough because they need to understand. However many of them keep on asking but "**why but why**".* **Male Social Worker**

One provider reported that these survivors require both follow up and counselling to help them access and uptake the entire package of care .Some of the survivors at times are in denial when they present for care.

> *"The kids or those under 18, you may need to take time with them, reassure them because they do not understand. And some of them are even in denial. They have come, the pregnancy is almost term but they are completely denying they are not pregnant."* **Female Nurse**

6.5.3 Service delivery considerations required in management of child survivors

We sought to establish from providers the considerations required with focus on medical examination; psychosocial support and follow up; injury management; physical examination; collecting forensic evidence ;treatment for STIs; pregnancy prevention; HIV testing and counselling; and history taking.

a) Evidence collection procedures

Most of the providers acknowledged the importance of retrieving evidence from child survivors of SV. While the importance of timely collection of evidence was noted, providers indicated instances

where survivors would present at the facility after evidence had been tampered with, majorly by discarding clothes worn by the child during the assault or bathing.

> *"Collecting forensic evidence is okay. However when victims are brought in they have already showered and changed their clothes. If you ask for the clothes they say they threw them away…."* **Male Medical Officer**

It was also indicated that evidence collection is at times interfered with when collection is done by providers situated in different service delivery points in the health facility.

> *"Forensic examinations I think if it's done in a place that's away from the outpatient the examination. It can be done comprehensively if samples need to be taken can be taken when there's privacy to enable the children to have confidence in the person who is taking them. You find that the person taking these samples is not the person who will see this child later when the results are out. So if it's done in a specific place by a specific person then it would give a good follow up"* **Male Clinical Officer**

There were discrepancies in the documentation of evidence collection from the survivors as highlighted from a review of existent records. In most instances, specimen analysis was documented in the laboratory register whereas the PRC form lacked documentation from the clinicians requesting laboratory analysis.

In a few instances, providers failed to collect evidence from paediatric survivors due to the lack of equipment and supplies.

> *"I think we should have those basic things weighing scale in place, small paediatric speculum, the examination room not withstanding and personnel".* **Male Nurse**

The difficulty in obtaining consent for examination from well-wishers who accompany children to the hospital in instances where the physical damage to the child is severe, and the parent is not available, was also mentioned by a provider:

> *"……sometimes you see like a child may be…may be assaulted and then it is not the mother who brought the child to the hospital. So you see it is like you have to contact the relatives to come and give consent for examination. You see some of them if the…the…the damage is extensive, we have to take this child to theatre for …for examination under anaesthesia. Of course a teacher or any other person cannot give consent unless you involve the parent. And if it is not there you see we have to involve the police, the children officer so that we can go ahead with it."* **Female Nurse**

Providers recognised the importance of collecting comprehensive evidence from survivors and the need for measures to be put in place that will ensure timely reporting of cases before evidence is contaminated with or destroyed, and systematic collection of evidence by providers to minimise having the survivors being attended to by different providers. Where possible, providers cited that the person undertaking the physical examination should also obtain the forensic evidence and be of the same gender as the child.

b) History taking considerations for child survivors

It was widely recognised that providers put great emphasis on history taking as a component of PRC management. In addition to this, providers indicated survivor age and details of the assault as key components that have a bearing on the quality of information a provider can obtain from a child survivor. In some instances, the presence of an adult care giver in the room is also considered to pose a challenge to the children from whom the history is being obtained.

> *"For a child, history taking, takes a long time because you may not exhaust it {obtaining history} all at casualty. But at casualty mainly they pick the complaints. Because this child has been brought maybe by the mother or whoever rescued the child. But for a child, she can give her story. But for a child you need to really, as you take history from the mother you also take history from the child and that is why you need more time with the child so that you create rapport and to allow her to really confide in you so that she can give you information. Remember this information she did not even tell the mother. So you are not special that she will tell you. Until you really convince her that you will not tell….you reassure her that surely you will protect her if she gives you the information."* **Male Nurse**

One provider mentioned that while it is important for them to be patient with the survivors during history taking, this may not be possible due to the long patient queues at the casualty department. As such they end up not collecting all the relevant history. This omission by during examination was cited by the laboratory technologists as a challenge they face when providers request for samples that do not tie in with the complaint the survivor presented with. In other instances, the laboratory personnel are forced to take more history from the survivors, but this is never documented as the laboratory does not have registers to document any history they obtain from patients.

> *"History taking this where I think is where we he have a lot of problems with the clinician sometimes it radiates to the lab because you find that some of this survivors they are brought and you see they are uncomfortable you want to them a few questions and you realize that maybe the clinician did not take the proper history."*
> **Male Laboratory Technologist**

The use of electronic data capture system during history taking was reported to contribute to the flaws in history taking due the limited nature of information required from patients.

"History taking is very poor because we use an electronic system and this system limits the clinician who is taking the history because it has very specific things that you can write there but if it can be documented manually it would be very good or if we had an electronic system that is going to accommodate what you will ask the client it would be very good."
Male Clinical Officer

One of the social workers stated there is need for a history capturing mechanism that would allow for the different providers attending to the child to fill in the gaps during their interaction with the child instead of relying on the history captured by one provider.

"I think we should have a very good format where this history should flow right from the background all the way to the family how they live, how many they are in the family, the age of the child we should know that. I think we should have ranges of forms where these children now the history taking should flow other than now having this clinician taking the history and maybe you will find another person will maybe find some gaps yes. And also their information should be kept very well and well protected." **Male Social Worker**

c) HIV counselling and testing for child survivors

According to the national guidelines on the management of survivors of sexual violence, the HIV test is to be conducted in the laboratory in order for survivors to be given results. According to a **Female Nurse Counsellor**, HIV testing has to be done in the laboratory *"for the legal matters and to make them {results} more official we send them {survivors} to the lab so that they can have the tests and results written and stamped."* This however was reported by some providers as a hindrance in survivors receiving comprehensive counselling and testing services.

"And if it can be done somewhere else like in the youth friendly centre where in future all these patients will be seen, it can be easier so that they can be done for the counselling the same time when testing is done. Instead of doing it in the lab whereby counselling is never done. So even after getting the HIV result, it is positive, what next? They are just given the results but they have not been counselled." **Female Nurse**

One provider reported that HIV counselling and testing is "not done exclusively because when it's done we write for them the lab when they go to the lab they are not counselled for the HIV status...When the results come they are given PEP and they are just told the side effects of PEP they are not counselled before testing and after testing."
Male Clinical Officer.

This was also affirmed by a male Laboratory Technologist who stated that, *"we don't do counselling, as it is done outside {outside the laboratory} by the nurses."*

d) Physical and medical examination of child survivors

Many of the respondents reported conducting these examinations to help determine the type of care to be accorded to survivors or advice on instances where the child might require a hospital admission for a given duration.

It was reported by providers that those involved in examination procedures ought to be well trained and have the skill set required to address anxiety presented by children during examination.

> *"Whoever is attending to that child or to that person who has been sexually abused should be well trained, when it comes to taking the specimen it should be somebody who knows whatever she is doing.*
>
> **Female Counsellor**

The importance of conducting the examination procedures in privacy was cited by many of the providers. This also allows for documentation of the examination procedures and findings.

> *"..Privacy and assurance and rapport with the client so that she is free of fear. So that we are able to examine, she will give proper history ....."* **Female Nurse**
>
> *"It should be done in a specific place like a room or a centre within the hospital that is specifically designed for that because now like in outpatient when they come you take them to the couch you are not able to examine them fully. When you are in a specific place you will be able to examine this person for injuries and if there is any documentation you will be able to fill."* **Male Clinical Officer**

e) Pregnancy prevention among child survivors

While the technical considerations on management of child survivors of SV cite the importance on tanner staging in determining how pregnancy prevention should be undertaken, no provider reported on this.

One provider reported that:

> *"Majority of the times we ignore giving the Postinor-2 to prevent pregnancy. We just assume that these are kids. But we agree that nowadays even young children of 9 years are getting pregnant. So I wish we can improve on issuing this Postinor-2 to all children above 9 years and above."* **Female Nurse**

Providers reported that survivors who report to the facility at night are never given EC as the pharmacy department closes at 5pm.

> *"And it {EC) should be always be available. Even if it is in the OPD. Instead of when they are coming at some late hours and maybe there in nobody in the pharmacy and you are telling her to go and come tomorrow. So I think they {EC) can be in placed in strategic places, like in the OPD, which is open 24 hours."* **Female Nurse**

In the case of a SV related pregnancy, providers stated having attended to survivors who reported to the hospital upon conceiving from the assault. According to some of the providers, handling of such cases is complicated as the facilities only provide Emergency Contraceptives (EC) as opposed to abortion

> *"Most of them {survivors} come maybe a week later. And sometimes they come when they are pregnant, or when they come to report when they are already pregnant and they tell you 'I was raped last month' and they did not come. …… We have seen several who come to report when they are pregnant and then they say they were raped. So…advocating more to them that once they are raped they come."* **Female Nurse**
>
> *"We don't advocate for abortion"* **Male Social Worker**

Providers also reported on the need for continuous counselling to address pregnancy management .

> *"…the first session of counselling is not enough, we are supposed to take it as a process whereby this child will be done the first counselling whether the child is already pregnant. We need to walk with this child, let us support this child morally. If the child feels she doesn't want this child {to carry the pregnancy to term}, we make the arrangements… for this baby."* **Male Social Worker**

f) Provision of Post Exposure Prophylaxis (PEP) to child survivors

The National guidelines on management of SV state that PEP should be provided to all survivors who present within 72 hours. The dosage to be given to paediatric survivors is also stipulated alongside the blood monitoring tests that are to be undertaken before and during the 28 days a survivor will be on PEP.

Providers interviewed acknowledged that PEP is given to survivors, but on a weekly basis to allow for blood monitoring and liver function tests to be carried out. PEP is also only given to survivors who test HIV negative. According to a Female Nurse, "they are given a weekly dose of the drugs {PEP} for 28 days "during which they are reviewed weekly. A 3 - day dose of PEP is given to all survivors who report within 72 hours "whether they are tested or not," and the weekly dose is given once "they are tested {for HIV} later, "and a full haemogram undertaken."

It was indicated that survivors who report during the weekends are only given drugs enough to last them though the weekend. However, there is a lack of systems in place to ensure that these survivors return to collect the full dose of PEP in addition to accessing adherence counselling.

> *"…. if its weekend we give them for three days and then on Monday they come for the full dose and for the return part I am not sure how many have been returning but {name withheld} says some of them return some of them don't. That's another challenge."*
> **Male Medical Officer**

One provider stated that at times they experience stock-outs of paediatric PEP dosages.

> *"When it comes to PEP, sometimes or you see we do not have a specific allocation for these clients {paediatrics} due to stock outs."* **Female Pharmacist**

g) STI management among child survivors of SV

Providers reported that antibiotics are also given to child survivors. However information on STI drugs is given to parents as opposed to the children as the children cannot comprehend the information.

> *"You should educate the child on the importance of this drug that you want to offer. For STIs ,t some of them may not be able to comprehend what an STI is like a child who is four years or three years but we continue to administer the drug but let the guardian or the caregiver who has accompanied the child have that knowledge."* **Male Social Worker**

In one facility, a health provider stated that survivors are required to pay for STI drugs, despite the medical treatment regulations on the Sexual Offences Act clearly stipulating that PRC services are to be offered at no cost.

> *"They are not given for free, they are charged."*
> **Male Pharmacist**

h) Psychosocial support and follow up

Majority of the providers interviewed stated there is need for child survivors to be offered intensive counselling due to the trauma associated with SV.

> *"The psycho-social support should be offered over a long period of time because I don't know whether some patient would come back or they disappear {during the one month duration of care}. So I think we should have a follow up mechanism if not here in whatever institutions there is or the nearest facility, if we could be able to do follow up because I think some of this might affect them later in life."* **Female Pharmacist**

While they acknowledged the need for follow up to ensure that child survivors adhere to the treatment plan, many of the providers stated that most of the survivors did not return to the facility for follow up. This was either linked to the distance survivors have to cover to get to the facility or their reliance on adult care givers.

> *"Maybe there should be enough counsellors because now for this facility, we depend a lot on social workers. And social workers sometimes tend to be quite busy, we just have a few."* **Male Clinical Officer**

In addition there lacks a structured follow up mechanism to and from the community to help monitor progress made by the paediatric survivors initiated on care and treatment. Providers also reported shortage of counsellors and social workers as one of the reasons why counselling and follow up is not effectively done.

> *"Psychosocial support sometime has problems because you see this child is not the one to decide for herself, it is the guardian who will decide on what to do and the way forward."* **Female Nurse**

To address this gap, some providers indicated that community health workers under the community health strategy can be used to help do close follow up of the survivors in addition to referring them to the hospital for continued care and support.

> *"We should link these kids even to the…to the maybe to the community health workers who are working in the community, because the moment they leave here, some do not even come back."* **Female Nurse**

Providers also reported the need for care givers to be offered psychosocial support to enable them better support their children who have undergone sexual violence.

> *".....because the guardians will take care of them, they need to be counselled on how to take care of this child who is not able to…to understand what is happening. Counselling is also very vital. Both to the guardian, to the parents and also to the victim."* **Female Nurse**

6.5.4 Provider capacity in delivery of PRC services to child survivors

A Majority of the providers stated the need for specialised training on management of children, with focus on "counselling", "proper evidence retrieval", " developmental stages", "filling in of PRC forms2, "appearing in court to give evidence", "evidence to be collected by offence", "how to sensitively handle paediatric survivors", "Antiretroviral therapy", and "communication skills."

"Children are not small adults so you should handle them as children with all their special needs so I think with that in mind we should be trained on how to handle children generally knowing it is not a small adult ….." **Male Clinical Officer**

On evidence collection it was reported that;

"…..the part of forensic when we bring the specimens actually we don't know how they are tested, how long they would take before the results are out. Actually what is needed because when we remove the swabs from the mouth of the perpetrator, or when we remove the pubic hair actually that procedure we don't know how it is done, as far as forensic is concerned I don't think we the health workers have the knowledge and it is important that we know."

Female Nurse

"..Because in most cases some children, in some rape cases you will see that this client {child} has been requested this number of tests, when you get another one {another child) they are {tests requested for} different. Like there was a case where by clinician request for HVS, vaginal swab for microscopy culture and sensitivity but another client comes in they just request for microscopy. So I think there's a gap they do not know exactly what test am I supposed to run. So I think training will help a lot."

Female Laboratory Technologist

Providers cited the need for a comprehensive training package on PRC management and the need to be sensitized on the role of each service delivery point in management of children.

We sought to establish if providers have experienced any challenges in getting this training, and some of the reasons given included:

- *"lack of awareness on when these trainings are conducted";*
- *" shortage of staff at the facility which makes it difficult for all providers to be released for a training";*
- *" lack of financing to pursue such trainings at a personal level" ;*
- *Selection bias where persons who don't attend survivors are the ones who get the opportunity to go for these courses"; and*
- *"Lack of information on where to get such trainings."*

6.5.5 Existence of standard operating procedures for managing child survivors

None of the facilities have Standard Operating Procedures (SOPs) on managing paediatric survivors of SV. Providers interviewed mentioned only having SOPs on dispensing ART. However, there was lack of protocols on how to obtain and manage evidence, offer counselling and administer the PRC form. They however indicated adapting the existing generic SOPs which are most suited for adult survivors to attend to child survivors.

> *"For children I have not seen. I have only seen a general one-SOPs"*
> **Female Nurse Counsellor**

Some of the providers had used the PRC and P3 forms, citing difficulty in using Part B of the PRC form which captures the psychosocial assessment of the survivor. Other documentation protocols used by providers include PEP register, ART register, PRC register, ANC registers, patient files and laboratory registers. Two providers reported never having seen or used the PRC forms.

6.5.6 Cost of services to survivors

While the medical treatment regulations on the Sexual Offences Act state that all PRC services are to be offered at no cost, we established that survivors of SV are in some instances required to pay for STI drugs. One respondent also mentioned that survivors who conceive following a sexual violation may at times be required to pay for services in the laboratory.

> *"Unless we are told otherwise they {those who are pregnant) will pay, but if they note that from the MCH and they tell us we will do the test for free. But if we are to follow the system of the hospital they will pay, but if we are told that this pregnancy was due to the rape or to all that that pertains the rape definitely we can do the test for free there is a waiver system in the hospital whereby such patients can be waived."* **Male Laboratory Technologist**

Survivors also pay for the P3 form to be filled in for them.

> *"They only pay a very small fee of 200/- when they are being filled the P3. And for sure if the survivor doesn't have money he or she will be waived."* **Male Social Worker**

However, in both facilities respondents mentioned on the existence of a waiver system from which survivors are not required to pay for most of the services, as long as they indicate during the triaging that they are survivors. However, during the observed sessions of survivors under this study, a guardian of one of the children who was admitted following a sexual violation paid for the admission and drugs received.

6.5.7 Considerations on improvement of service

We sought to establish from providers what they thought in their view needs to be improved to ensure survivors receive comprehensive care and support. Most providers reported that their facilities were doing all that is required to ensure that:

> *"They provide everything for free, including the tests, including the treatment, including the filling of the P3. They do them for free and I think in that area they are doing well."*
> **Female Nurse**

Many respondents indicated need to strengthen and improve on the follow up mechanisms for survivors. Some of the suggested areas of improvement include "designated service delivery points", "staff member to accompany survivors across the different service delivery points", "waive all PRC services including antenatal and post-natal care", "ease identification of these cases from the reception area to the examination room."

Interview Excerpt on how provider fatigue affects negatively on service delivery

"Yeah, in fact there are some areas that need some strengthening. Because sometimes you are…these shortage in the hospital, yes. Sometime you realise that those clients do not receive the kind of attention they are supposed to receive. Sometimes they come in and the person who is there {at the service delivery point} is so tired because there is no specific area or specific person who is specifically dealing with this client. And sometimes they {survivors} are coming in and they find that maybe in some of those areas where they are supposed to be attended, there is nobody {no provider}. Some areas {service delivery points} are closed, other areas are having people who are already so fatigued. So I would say that. And that is how… why I would still come back to saying that we need somebody who is fresh and who knows that 'I am here specifically to attend to a child post rape care patient who comes.' You know when your mind is set you will not be overworked. Such that even when this person comes, actually you do not give the quality services you are supposed to give. Because you have already been overused, you have already…you are already so tired. But in those other areas where they are investigates, where they are taken samples and all that, we need a person who is giving more attention and who is not so tired." **Female Laboratory Technologist**

Most of the providers suggested that a designated service delivery area to be set up for children with providers trained on how to manage paediatrics and with a waiting or playing area that is child friendly. In addition they stressed on the need for measures to be put in place to ensure that survivors easily navigate through the health care system.

> *"you see everybody is busy, sometimes we forget the survivors, sometimes I walk at the reception there asking people what is the issue, you realize that a survivor has stayed in the lab sometimes for one -two hours so all that, supposing now this survivor takes two more hours in another department, they get frustrated and they sometimes don't want to be followed up because of the delay. I don't know whether something can be done when they get into the hospital at that point they are followed up because structures {designated service delivery points for children} will not come very soon. To see that they are given services on time"*
> **Male Laboratory Technologist**

Providers also mentioned the importance of community awareness to address the delayed reporting and tampering of evidence.

> *"….if we educate the community too and tell them if this and this happens it's good for you to do ABCD and these clothes are not supposed to be washed they should be kept. You are not supposed to take a shower because most of them when they come they do not have that knowledge."*
>
> **Male Clinical Officer**

According to other providers, service delivery could be improved upon by having more personnel trained and assigned to handle these cases.

> *"…I would think we need more health providers and also more counsellors so that immediately these victims come they don't wait for long or they are not booked because maybe the counsellors are few they would be told to come tomorrow because the counsellor won't be able to handle the number of cases ."* **Male Nurse**

The need for an integrated service delivery approach was also mentioned. Providers cited the distances in between service delivery points as one of the contributing factors to lack of access to comprehensive services.

> *"Maybe if there could be like integrated services so that when they come the health provider will give what is necessary then the examination is done immediately then the counsellor could just be near and also the laboratory. If there could be integrated services for victims of sexual violence it could serve them better because these days the departments are far apart."* **Female Nurse**

The need for integrated services was further mentioned as a way through which delays in service delivery could be minimised.

> *"I would like talk of integrated kind of room where by when this person comes you are able to...to take the history, you are able to do your examinations, you are able to fill the forms…the relevant forms, you are able to give the drugs that they need, and also to do the counselling. They can get all that at one point …it is a place whereby they {survivors} come, they get a caregiver who can do all that to them instead of keeping sending them from one department to another."* **Female Nurse**
>
> *"… sometimes when those specimens are taken, you realise that even the person who is dealing with them in the lab is dealing with all the other patients. So sometimes you realise that there is a lot of delay. The person who is giving care to this client is already waiting for the results. Yet the person who is in the lab is not releasing the results as fast as he should because he is also the person who is dealing with every other patient. And some of them are quite sick anyway. So sometimes you realise there is a lot of delay."*
>
> **Female Laboratory Technologist**

All the providers reported on the need for follow up mechanisms to enable survivors adhere to the treatment schedule. Upon being asked to share their view on how services can be improved from a survivor's perspective, respondents indicated having been informed by survivors that health workers need to improve on their attitude and the time taken in providing care.

> *"One is the attitude of the clinicians, they {survivors} feel that they are not handled well, they need clinicians to change their attitude when handling them. They also said they take quite a lot of time before everything is finalized…from the time they come to the time they leave. ..And it takes too much time. One told me that after she came she left empty…she came empty and she left empty without someone to talk to and to express herself."*
>
> **Male Clinical Officer**

Few providers mentioned the need for care givers to be sensitized on the side effects of PEP to better support child and adult survivors when they experience any of the side effects. The care givers also ought to be equipped with knowledge on why they need to support their children in accessing care as scheduled.

> *"Some of them will take the PEP because we are with them in the ward, but when they go home because of side effects some are not able to continue."*
>
> **Female Nurse**

7. CONCLUSION AND RECOMMENDATIONS

This section provides an overview of the major findings that are key in helping improving access to quality and comprehensive services by child survivors of sexual violence. The conclusions are presented based on the study objectives and key recommendations presented to inform policy and practice.

Services offered to child survivors of sexual violence

The national guidelines on management of sexual violence highlight the post rape care package to be offered to all survivors of sexual violence. This includes: HIV testing and prophylaxis, STI management, Pregnancy prevention and management, trauma counseling, physical examination, collection of forensic evidence and completion of the PRC and P3 forms. This study established lack of protocols and/or service delivery charters to aid providers on how to administer the PRC package to child survivors. This study revealed that while PRC services are currently available in the health facilities, not all child survivors are able to access these. In some instances access to PEP, counselling and pregnancy prevention, is dependent on the age of the survivor and the time at which the case was reported. Furthermore, availability of services is largely determined by availability of drugs, medical supplies, equipment and trained health workers. While the medical regulations on the implementation of the sexual offences Act stipulate that PRC services should be offered at no cost to the survivor, this was not the case as the study revealed that survivors are required to pay for STI drugs and P3 forms.

Most of the survivors spend an average of 2 hours within the facility. The longest waiting time was found between outpatient, laboratory and pharmacy service delivery points. It was observed that majority of the survivors did not like being attended to at different service delivery points and being asked to narrate their story at each service delivery point. In addition the movement across different locations in the hospitals impacts on the quality of services received and perception of clients, and consequently negatively impact on their uptake of follow up care. Referral mechanisms for pediatric survivors both within and outside the health facility are not well documented, hence difficulty in ascertaining the extent to which these survivors access the comprehensive services. Respondents reported sometimes giving verbal referrals or using written notes that are not standardized.

In addition, uptake of the services through follow up care for child survivors is largely dependent on their care givers, many of whom lack sufficient knowledge on the importance of the different components of care- including importance of timely reporting, adherence to PEP, access to counselling for the five sessions outlined in the national guidelines.

Access to services available at the health facility was found to be largely influenced by the time of reporting at the health facility. The study established that in both facilities survivors are only able to

have P3 forms filled in for them on specific days of the week. As a result, survivor's presenting after 5 pm, during the weekend and/or public holidays are compelled by the circumstances to make several return trips to the hospital before undergoing laboratory investigations, and receiving PEP, P3 form, and counselling. Transport costs also serve as barrier to access due to the several visits survivors are forced to make to the health facility.

RECOMMENDATIONS

1. Standard operating procedures on management of child survivors of sexual violence should be developed at national and county level to facilitate delivery of standardized care across all health facilities

2. Development of referral mechanisms for child and adolescent survivors of sexual violence. This will help improve on quality and continuity of care through follow up and effective documentation. A referral system should be developed for all institutions and actors involved in delivery of PRC services.

3. Care giver and survivor literacy materials on management of sexual violence should be developed. These should highlight the services available, importance of timely reporting and adherence to care, and value of counselling to address mental health needs of survivors. A provider information checklist should be developed to enable them sensitize child survivors and their care givers on the available PRC services.

4. Enhance supply of commodities and equipment required for the management of child survivors of SV.

5. To reduce on the anxiety created among child survivors and their guardians as they wait to be attended to, we recommend for facilities to be stocked with play materials for children and have waiting bays with child friendly and easy to understand IECs.

Quality of services offered to child survivors

Lack of skilled providers in management of this population group poses a challenge in delivery of quality services. There was no difference in how child survivors were managed in comparison to adult survivors. The study revealed that few providers have been trained on management of child survivors of violence and that the facilities lacked tools (equipment, protocols, and supplies) essential for the management of child survivors.

Most of the service delivery points are not friendly to the children, as the equipment therein is inadequate. Lack of safe shelters for children abused within their own family environments also poses a challenge in uptake of follow up care. This in itself poses further risks to survivors abused by their relatives or persons close to them.

Despite providers stating that they offered trauma counselling to survivors, this was however found to be more of information giving sessions on available services, as opposed to counselling. Furthermore, documentation of this service was non-existent. In one facility, the provision of counselling services was abdicated to one counsellor. Some of the providers indicated their frustrations in managing child survivor due to lack of debriefing sessions that would allow for them to obtain psychological support. In addition, the lack of patient follow up mechanisms makes it challenging for providers to remind child survivors and their care givers on the scheduled counselling sessions and clinical follow up visits. There is minimal effort made to follow up cases of survivors once they leave the health facility. A counselling protocol for children exposed to sexual violence is also non-existent, resulting in many of them not being offered pre and post-test HIV counselling. In addition, providers cited difficulty in counselling child survivors on pregnancy prevention and management, and on drug adherence. Chain of custody of evidence is critical in management of data and evidence obtained from survivors. However, none of the two facilities under investigation had lockable storage provisions for evidence and data obtained from survivors. There also lacks standard operating procedures on collection and transfer of evidence from one service delivery point/provider to the next within the health facility.

RECOMMENDATIONS

1. The Ministry of Health should devise mechanisms that promote the setting up of child friendly examination areas where children can be handled with utmost privacy. In addition, each service delivery point should be manned by a provider trained on management of child survivors.

2. Health facilities should have adequate commodity supply and equipment to enhance delivery of comprehensive services to child survivors of sexual violence.

3. There is need for enhanced psychosocial assessment of children and strengthened referral to safe shelters for those abused within their homes. The health facilities should explore opportunities to engage facility based social workers to undertake these assessments, counselling and follow up to ensure provision of quality of psycho-social support and enhance continuity of care through follow up.

4. All health facilities should put in place mechanisms to promote safe storage of documents and evidence obtained from child survivors of SV.

5. A child friendly counselling protocol should be developed and providers trained on how to offer counselling on HIV, STI, adherence and pregnancy prevention or management without causing harm to the child survivors and their care givers.

6. There is need for a counselling protocol to be developed and providers trained on how to offer HIV, STI, adherence and pregnancy related counselling to child survivors.

Utilization of national documentation protocols

Level of utilization of national documentation protocols in managing child survivors is inadequate. The review also demonstrated that the services offered to child survivors were not accurately documented. This inadequate documentation of services provided could compromise on judicial outcomes in instances where survivors and their guardians choose to pursue justice. It was not possible to establish the counselling package that is offered to survivors given the inadequate utilization of the trauma forms. The electronic medical records system currently in use in public hospitals does not adequately provide for the capture of information obtained from survivors accessing post rape care services. This was one of the components of the PRC package that was disliked by survivors and their care givers.

Some of the facilities did not have the national protocols, namely PRC forms, PRC registers, consent form, trauma counselling forms. This resulted in poor documentation of services offered to survivors. In addition these documents are not securely stored.

The study revealed that the national documentation protocols are located in different service delivery points. In addition, the tools capture similar information, resulting in the child survivor having to repeatedly provide this information to the different providers. This was found to cause anxiety among the children.

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ANNEXES

ANNEX 1: CLIENT FLOW PATHWAYS

Survivor's Number	Observation day	Time arrived at facility	Observation type(New session/	Room 1	2	3	4	5	6	Time exited from facility
1	Day 1	**1430**	New	Triage **(2mins)**	Examination **(3 mins)**	Triage **(6 mins)**	Counselling **(4 mins)**	Laboratory **(14 mins)**	Pharmacy	**1640**
2	Day 1-4	**1430**	New	Triage **(0 mins)**	Examination **(0 mins)**	Laboratory **(10 mins)**		-	-	**1540**
		1200	Follow up	Examination **(13 mins)**	Counselling **(3 mins)**	Laboratory **(36 mins)**	Examination **(5 mins)**	-	-	**1424**
		0944	Follow up	Counselling **(7 mins)**	Examination **(3 mins)**	Triage **(0 mins)**	Wards **(0 mins)**	Laboratory **(23 mins)**	-	**Admitted**
		1208	Follow up	Counselling **(0 mins)**	Examination **(21 mins)**			-	-	**1453**
3	Day 1	**0930**	New	Counselling **(5 mins)**	Pharmacy **(2hrs 19 mins)**	Referral Outside the facility		-	-	**1012**
4	Day 1	**1030**	New	Counselling **(0 mins)**				-	-	**1059**
5	Day 1-3	**1540**	New	Examination **(6 mins)**	Examination **(5 mins)**	Examination **(0 mins)**	Triage **(0 mins)**	Counselling **(0 mins)**	-	**1600**
		1200	Follow up	Examination **(28 mins)**	Counselling **(16 mins)**	Examination **(2 hrs 7 mins)**	Triage **(0 mins)**	Laboratory **(30 mins)**	Examination **(0 mins)**	**1600**
		1000	Follow up	Examination **(38 mins)**	Pharmacy **(0 mins)**	Examination **(0 mins)**	Waiting bay **(0 mins)**	Examination **(0 mins)**		**1129**
6	Day 1	**0900**	New	Counselling **(30 mins)**	Examination **(0 mins)**	Laboratory **(0 mins)**	Examination **(0 mins)**	Counselling **(0 mins)**	Examination **(12 mins)**	**1109**
7	Day 1	**1800**	New	Examination **(2 mins)**	Laboratory **(1 min)**	Examination **(3 mins)**	Pharmacy **(1 min)**	-	-	**1927**
8	Day 1	**1748**	New	Examination **(10 mins)**	Laboratory **(5 mins)**	Examination **(0 mins)**	Laboratory **(0 mins)**	Washroom **(0 mins)**	Laboratory **(0 mins)**	**1901**
9	Day 1	**1035**	New	Counselling **(2 mins)**	Examination **(3 mins)**	Washroom **(0 mins)**	Laboratory **(10 mins)**	Examination **(8 mins)**	Pharmacy **(5 mins)**	**1315**
10	Day 1	**1448**	New	Triage **(0 mins)**	Examination **(13 mins)**	Washroom **(0 mins)**	Examination **(7 mins)**	Laboratory **(0 mins)**	Examination **(0 mins)**	**1642**
11	Day 1	**1445**	New	Triage **(0 mins)**	Examination **(16 mins)**	Washroom **(3 mins)**	Examination **(0 mins)**	Examination **(0 mins)**	Laboratory **(0 mins)**	**1621**
12	Day 1	**1605**	New	Examination **(0 mins)**	Laboratory **(10 mins)**	Examination (0 mins)	Laboratory **(0 mins)**	Examination **(6 mins)**	Pharmacy **(4 mins)**	**1941**
13	Day 1	**1215**	New	Examination **(0 mins)**	Laboratory **(8 mins)**	Examination **(3 mins)**	Washroom **(0 mins)**	Laboratory **(0 mins)**	Counselling **(0 mins)**	**1450**
14	Day 1	**1052**	New	Examination **(0 mins)**	Laboratory **(7 mins)**	Washroom **(0 mins)**	Laboratory **(0 mins)**	Examination **(2 mins)**	Laboratory **(0 mins)**	**1202**

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