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# Health Sector Inadequacies in Attending to Child Survivors of Sexual Abuse in Kenya: An Operations Research

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In 2015, LVCT Health (a Kenyan non-governmental organisation) conducted an exploratory study to assess the quality and comprehensiveness of services provided to child survivors of sexual violence at two public health facilities in Kenya. Both quantitative and qualitative data collection methods were used, including a retrospective review of 164 child survivor medical records, a health facility staff inventory, in-depth interviews with 31 healthcare providers and 19 exit interviews with 14 child survivors and their caregivers. Ethical approval was obtained from two independent ethics committees. Quantitative data were analysed using SPSS version 22, while qualitative data were analysed using NVivo 10 based on a thematic coding framework. The health facility staff inventory indicated that only two out of 581 providers had undergone previous training on the management of child survivors of sexual violence. Both health facilities lacked the appropriate equipment for the collection of forensic evidence from children and private rooms in which to conduct the clinical examination. Providers cited challenges in offering psychosocial support to children. Only 27 per cent of child survivors were documented to have received trauma counselling. There is a need for health facilities to enhance their human resource and infrastructural capacity to facilitate the delivery of comprehensive care to child survivors. © 2018 John Wiley & Sons, Ltd.

KEY PRACTITIONER MESSAGES:

- There is a need to develop child-specific guidelines for healthcare providers in order to ensure that child survivors of sexual violence receive good-quality services at the facility level.
- Healthcare providers in public health facilities need competency-based training to enable them to acquire knowledge and skills to identify and respond to child survivors of sexual violence, collect evidence, communicate with the children and offer counselling support to child survivors effectively.
- Services for child survivors should be centralised in health facilities to minimise the number of different contact points.

KEY WORDS: child sexual abuse; violence against children; post-rape care; sexual violence; Kenya

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**'An exploratory study to assess the quality and comprehensiveness of services provided to child survivors of sexual violence… in Kenya'**


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## Introduction

Sexual abuse of children aged less than 18 years is a global problem (Hillis *et al*., 2017; Lalor, 2004). The World Health Organization estimates that approximately 20 per cent of girls and five to ten per cent of boys are victims of sexual abuse all over the world (Finkelhor *et al*., 2013). According to the 2010 Kenya violence against children survey (United Nations Children's Fund Kenya Country Office *et al*., 2012), about 11 per cent of females and four per cent of males aged 13 to 17 had experienced sexual abuse. At least 32 per cent of adult females and 18 per cent of adult males reported experiencing sexual violence during their childhood. Out of these, only a few reported receiving services (such as from a clinic or non-governmental organisation) for any incident of sexual abuse (United Nations Children's Fund Kenya Country Office *et al*., 2012). Data from the Moi Teaching and Referral Hospital show that 70 per cent of survivors attending between 2007 and 2010 were children aged less than 18 years, while the Gender Violence Recovery Centre recorded 1167 cases of sexual abuse committed against girls less than 14 years between the years 2011 and 2012 (Gender Violence Recovery Centre, 2012; National Council for Population and Development, 2012).

**'[In Kenya], about 11 per cent of females and four per cent of males aged 13 to 17 had experienced sexual abuse'**

Child sexual abuse has serious impacts on victims' physical, social and mental health, and wellbeing in childhood and adulthood (Dube *et al*., 2005; Putnam, 2003; Reza *et al*., 2009). The most commonly documented consequences include the adoption of risky sexual behaviour, sexualised behaviour, symptoms of post-traumatic stress disorder, physical injury and substance abuse (Coren *et al*., 2009; Deblinger *et al*., 1996; Hillis *et al*., 2017; Howard and Wang, 2003; Macdonald *et al*., 2012; McClellan *et al*., 1996; Silverman *et al*., 2001). Consequently, child survivors of sexual abuse require: health services for the prevention of Human Immuno-deficiency Virus (HIV), sexually transmitted infections (STI) and pregnancy; psychosocial support through counselling and referral to safe shelters; and the collection and documentation of medico-legal evidence (Fernandez, 2011).

**'National guidelines on the management of survivors of sexual violence stipulate that all survivors should receive comprehensive services'**

In Kenya, national guidelines on the management of survivors of sexual violence stipulate that all survivors should receive comprehensive services, which include: post-exposure prophylaxis (PEP), emergency contraceptives, STI drugs, counselling and laboratory-related services; and that services provided should be properly documented (Ministry of Health, 2014). Additionally, the Ministry of Health has provided data tools to aid in documenting services offered to survivors. These include: laboratory, counselling, pharmacy, and sexual and gender-based violence (SGBV) summary registers; a post-rape care (PRC) form; a rape trauma counselling form; and the Kenya police medical examination form (also referred to as the 'P3 form') which links the survivors to the justice system.

Despite the existence of national protocols to inform service delivery, little is known about the extent to which they accommodate the needs of child survivors of sexual abuse. The national guidelines on the management of survivors do not specifically provide standards to be observed in the case of child survivors of sexual violence. It is therefore not clear what measures have been put in place by providers to ensure that child survivors of sexual violence receive standardised, quality and comprehensive PRC services. A study that was undertaken by Wangamati (2014) in Kenya revealed that shortages of



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equipment, supplies and drugs were some of the hindrances to the delivery of high-quality PRC services in public health facilities. Furthermore, there is limited information regarding the capacities of healthcare providers and infrastructural support in health facilities to facilitate the provision of comprehensive services to child survivors of sexual violence. Moreover, little is known about child survivors' own experiences of and satisfaction with PRC services provided in public health facilities. It was against this background that we undertook this study to assess health facility responsiveness to child survivors of sexual abuse, and to determine ways in which the Ministry of Health can enhance the delivery of these services in health facilities.

**'Little is known about child survivors' own experiences of and satisfaction with PRC services'**

## Design and methodology

This exploratory study was undertaken by LVCT Health (a Kenyan non-governmental organisation) from January to July 2015. The study sought to explore the following: (a) provider capacity to respond to the needs of child survivors of sexual abuse; (b) use of national protocols to document services offered to child survivors of sexual abuse; (c) receipt of the minimum package of care by child survivors; (d) provision of psychological support; (e) collection of forensic evidence from child survivors; and (f) level of child and caregiver satisfaction with services received.

### *Study sites*

The study was conducted in one rural and one urban public health facility in two counties in Kenya. The two hospitals were selected because they are geographically located in areas with a reported high occurrence of violence against children. The two facilities each receive approximately 20 child survivors of sexual abuse per month.

**'The study was conducted in one rural and one urban public health facility in two counties in Kenya'**

### *Data collection*

Both quantitative and qualitative methods were used. Quantitative approaches included a retrospective review of medical records ($n$ = 164) in which data were captured from survivors aged less than 18 years who had accessed PRC services from January to June 2015. The extracted data included client demographics, time of the assault, time of presentation for health services and services offered to child survivors of sexual abuse. The focus of the review was to establish the services offered, and the extent of completion of the services offered to survivors within existing national service delivery tools for PRC. National sexual violence documentation tools that were reviewed included: PRC forms; SGBV, laboratory, trauma counselling and pharmacy registers; and P3 forms. In addition, exit interviews with child survivors and their caregivers were carried out to assess their level of satisfaction with the PRC services received. Fourteen survivors and 19 caregivers were interviewed before they left the health facility.

Qualitative data collection entailed in-depth interviews with 31 health providers who attend to cases of sexual abuse (administrators, nurses, physicians, laboratory technologists, social workers, pharmacists and counsellors stationed in various departments, including outpatient/casualty,

**'In-depth interviews with 31 health providers'**

laboratory, pharmacy, counselling, social work departments and the comprehensive care clinic and wards). An interview guide was developed to elicit information on provider knowledge of the PRC service delivery package, provider attitudes towards managing child survivors and provider training needs, as well as the utilisation of national protocols during service delivery (see Appendix S1 in the online Supporting Information).

### *Data analysis*

Quantitative data were entered and descriptive analysis conducted using SPSS version 22.

All in-depth interviews were audio-recorded, transcribed verbatim in MS-Word and analysed using NVivo 10. Qualitative analysis was undertaken using a thematic approach where data were grouped based on the emerging themes by two researchers who subsequently analysed the data.

### *Ethical considerations*

Ethical clearance for this project was obtained from two independent ethics committees: The Population Council's Institutional Review Board in New York and the African Medical Research Foundation (AMREF) Ethics and Scientific Review Committee (ESRC) in Nairobi (AMREF-ESRC P164/2015). Research assistants involved in data collection underwent a three-day training programme on key ethical considerations in researching violence against children, data capture and management. Informed consent was obtained from all respondents prior to the interviews. In the case of child survivors, assent was obtained from them before parental consent was obtained. Parents/Care givers were given the opportunity to withdraw their child/ren from the study. Child survivors who could not fully comprehend the area of study were interviewed in the presence of their caregiver, while those who were able to comprehend the area of study were interviewed in the absence of their parents. Where children were unable to provide assent due to their age or they did not understand the study procedures described, then they were automatically excluded from the study, but their caregivers were enrolled upon consent. A trained counsellor was available to provide any additional counselling.

**‘Child survivors who could not fully comprehend the area of study were interviewed in the presence of their caregiver’**

**Table 1.** Total number of healthcare providers in the two facilities

| Healthcare provider | Health facility A | Health facility B | Total |
|---|---|---|---|
| Paediatrician | 2 | 1 | 3 |
| Obstetrician/gynaecologist | 2 | 1 | 3 |
| Medical officer | 19 | 10 | 29 |
| Clinical officer | 25 | 13 | 38 |
| Nurse | 238 | 135 | 373 |
| Counsellor | 15 | 7 | 22 |
| Social worker | 3 | 2 | 5 |
| Pharmacist | 9 | 6 | 15 |
| Anaesthetist | 6 | 4 | 10 |
| Radiographer | 7 | 4 | 11 |
| Laboratory technologist | 19 | 11 | 30 |
| Health records officer | 5 | 3 | 8 |
| Support staff | 23 | 4 | 27 |
| Nutritionist | 2 | 3 | 5 |
| Public health officer | 2 | | 2 |

## Results

Observations of 19 sessions of child survivors seeking care were carried out with 14 child survivors and their caregivers. The findings in the paper are categorised according to the various issues addressed in this study in order to assess the extent to which existing services are meeting child survivors' needs.

### *Provider capacity to respond to the needs of child survivors of sexual abuse*

The facilities had a combined total of 581 providers, as shown in Table 1.

Nine per cent of staff ($n$ = 52) had undergone an intensive three-day training programme on the management of gender-based violence using national training curricula. The majority ($n$ = 30) of the trained staff were nurses. Further analysis revealed that only two providers (one nurse and one clinical officer) had undergone training specifically focused on the management of child survivors of sexual abuse.

Through the in-depth interviews, the majority ($n$ = 25) of health providers stated the need for specialised training on the management of child survivors of sexual abuse, with a focus on counselling, proper evidence collection, filling in of data capture tools, presentation of evidence in court and how to communicate appropriately with child survivors. For example, with regard to evidence collection, one provider asserted:

**'The majority ($n$ = 25) of health providers stated the need for specialised training on the management of child survivors of sexual abuse'**

> '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)

Another provider indicated challenges in administering PEP:

> 'I don't know anything about ARVs [PEP], I just know generally that they are given for 28 days, what type are in use currently and the dosages all those things I don't know.' (Male clinical officer)

Respondents also cited challenges regarding how to communicate with children without causing any discomfort:

> '….right now, I don't have the knowledge. Sometimes you even fear to ask them [child survivors] because you don't have the skills; you may not know how to respond. But if I'm trained maybe I can be able to help her even much better to cope with the situation.' (Male laboratory technologist)

Shortage of staff trained in the management of cases of child sexual abuse also emerged as a concern for providers:

**'Shortage of staff trained in the management of cases of child sexual abuse also emerged as a concern'**

> 'Train more personnel, yeah, because, for example, when I am not around, my colleagues fumble with the cases. When you come here, you find… gaps in the [client] history. I wish every clinician could be trained in handling these survivors.' (Male clinical officer)

### *Use of national protocols to document services offered to child survivors of sexual abuse*

According to the Kenya *National Guidelines on Management of Sexual Violence*, providers are required to use the following tools: (1) The PRC form

(Ministry of Health form number 363) which enables them to document demographics and survivor history of the assault, samples collected, injuries observed and referrals given for other medical-legal services within and outside the health facility; (2) the SGBV register (Ministry of Health form number 365) – a longitudinal register that captures provider demographics, time of presentation at the facility, services given across different delivery points within the hospital, uptake of follow-up HIV care and counselling sessions; (3) Ministry of Health summary form number 364 – filled in on a monthly basis to provide a summary of clients attended to in a facility as documented in the SGBV register (the summary form then subsequently feeds into the national demographic health information system); and (4) a P3 form, obtained from a police station, to be filled in by a health provider who is to present evidence in court as an expert witness. All of the above tools were in use in the two health facilities.

Despite the existence of national documentation protocols for the management of survivors of sexual violence, all the providers reported that these protocols are not child-specific. According to one provider:

> 'The algorithms only say 'sexual violence survivors', so they don't specify if it is children.' (Male social worker)

**'Inadequate use of existing national documentation protocols by providers was established'**

Inadequate use of existing national documentation protocols by providers was established. The analysis of the medical records of child sexual abuse survivors revealed the following completion rates: 136/156 (87%) PRC forms; 92/156 (59%) laboratory registers; 46/81 (56%) trauma counselling forms filled-in; 48/110 (44%) pharmacy registers; and nine of 120 (8%) P3 forms. This finding was confirmed by information from the exit interviews, which indicated that only one of the 19 survivors was issued with a completed P3 form. In addition, out of the 81 child survivors who were documented in the counselling register to have received counselling services, only 45 were documented in the national rape trauma counselling forms.

### *Receipt of the minimum package of care by child survivors*

The minimum package of PRC services which should be available to survivors of sexual abuse includes prophylactic treatment (emergency contraceptive, HIV, PEP, STI drugs), injury management, counselling, evidence collection and analysis, documentation on the medico-legal form and referral for non-health-related services.

Of the 164 child survivors reporting to the facility for medical attention, 91 (55%) presented within 72 hours of the assault and 73 (45%) presented more than 72 hours after the assault. Review of the PRC register revealed that 51 (56%) out of 91 child survivors of sexual violence who reported to the facility within 72 hours did not receive PEP. On the other hand, 40 (55%) out of the 73 who presented more than 72 hours after their sexual abuse incidence were offered PEP. A total of 118/164 records (72%) indicated the gender of the child survivors, with females accounting for 93 per cent ($n$ = 110). Only 28 (25%) of the 110 female child survivors who accessed services were documented as having received emergency contraceptive pills. A further 21 (13%) of 164 child survivors did not have any documentation to show that they had received treatment for sexually transmitted diseases. Only 16



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(36%) of 45 records indicated that survivors had either disclosed the assault or received counselling on how to disclose the sexual violation to their social support system.

None of the child survivors of sexual abuse who participated in the exit interviews ($n$ = 19) received the full package of PRC services.

### *Provision of psychological support*

A number ($n$ = 15) of providers cited challenges in the provision of psychosocial support to child and adolescent survivors of sexual abuse. This was attributed to their lack of insight into some of the possible questions that the children might ask in a session and how best to communicate with the child on points raised in a session:

> 'Counselling a child may be tricky and tough because they need to understand. However many of them keep on asking, "But why [did this happen to me]?".' (Male social worker)

**'Providers cited challenges in the provision of psychosocial support to child and adolescent survivors of sexual abuse'**

While children were found to prefer using drawings to illustrate their psychological state, providers were not familiar with how to interpret the drawings:

> 'When dealing with children for them to express themselves you either give a book, a pen and a piece of paper and then you ask the child to draw whatever happened and by who and in fact they draw very funny pictures.' (Female nurse counsellor)

The need for training on how to address the mental needs of children was cited by some ($n$ = 9) of the providers:

> 'We should have people trained on children counselling. Because it is quite different from counselling adults. Like when we get these small children from ages around one to six… in fact six years it is quite a challenge. So we end up counselling the parents and not the kids. I would like to be trained in counselling those very young children.' (Female nurse)

### *Collection of forensic evidence from child survivors*

The record review indicated that blood (89.4%), urine (83.7%) and high vaginal swabs (77.0%) were collected from the majority of the child survivors of sexual violence. By contrast, less than one per cent had samples of pubic hair, nail clippings and foreign bodies were collected from less than one per cent of the child survivors. A small number (2%) of forms documenting the type of evidence that was collected were signed off by both the police and the health facility.

Health providers acknowledged the difficulty in obtaining high vaginal swabs due to the lack of essential equipment. The facility inventory revealed the lack of a working angle lamp, paediatric speculum, hand-held magnifying glass and glass slides to aid in evidence collection.

In addition, there was no private room in one of the facilities dedicated to the examination of child survivors of sexual abuse. Further, none of the facilities had a lockable cupboard for storing evidence, hence all the evidence collected and documented was not well secured.

**'None of the facilities had a lockable cupboard for storing evidence'**

**'Satisfaction… with the services seemed to be tied primarily to the waiting time'**

***Level of survivor and caregiver satisfaction***

These findings are drawn from the exit interviews with caregivers and child survivors. The satisfaction of survivors and caregivers with the services seemed to be tied primarily to the waiting time before receiving these services. At the two participating hospitals, survivors were observed to move between six different service delivery points, namely, triage, outpatient, counselling, laboratory, pharmacy and wards to receive the various components of the package of care. Consequently, the waiting time for child survivors ranged from zero minutes to four hours. One child survivor waited for more than two hours before being attended to during his second visit to the hospital for follow-up care. A survivor and a caregiver expressed their sentiments on this issue below:

> 'When I came first the doctors and nurses took long before attending to me.' (18-year-old female survivor)

> 'They [providers] are slow. You have to wait more than an hour at every point.' (Male parent of an eight-year-old survivor)

A few ($n$ = 5) caregivers also reported a dislike of being compelled by healthcare providers to report to the police even when they did not want to. One caregiver of a child survivor indicated that he did not like being 'Advised to report to the police even when she chooses not to as the perpetrator was a neighbour'.

One female survivor aged 16 years indicated dissatisfaction with being asked to 'go back home and come with my parent/guardian before receiving any kind of treatment'. Another survivor aged 14 years cited dissatisfaction with 'being asked about what happened in all the departments/place that I was referred to'.

The distance between the facility and other referral points contributed to frustrations among caregivers, as one was referred for medical attention to a facility that was 34 kilometres away before receiving emergency care.

However, caregivers expressed some level of satisfaction with the laboratory services and also 'being explained to side effects of PEP'. Child survivors, on the other hand, were satisfied with how the nurses and doctors took time to explain the issues to them, in addition to their being friendly, concerned and motherly.

## Discussion

**'This is the first study to detail the quality of services offered to child survivors of sexual abuse at public health facilities in Kenya'**

To our knowledge, this is the first study to detail the quality of services offered to child survivors of sexual abuse at public health facilities in Kenya. Findings of this study highlight the inadequacies of health facilities in attending to the healthcare needs of child survivors. The current integrated model of service delivery, while suited to low-resource settings, presents a major challenge to child survivors and their guardians given the lack of dedicated child-friendly rooms, the long waiting period before being attended to alongside other general patients and inadequate documentation of the services provided.

The integration of services for child survivors of sexual violence into different service delivery points presents an undesirable outcome for child survivors as they have to manoeuvre across different providers in order to

access comprehensive care. This practice in itself means that providers are not able to give adequate time to the provision of care offered by these child survivors of sexual violence. High attrition of survivors between the different services as per the medical records reviewed in this study ought to be addressed. This highlights a need for implementation models to reduce the number of service delivery points or increase the combination of services offered at each point. Services tailored towards child survivors of sexual abuse ought to be child-centred by providing them in a designated room.

Provider capacity in the delivery of services to child survivors of abuse is critical. These findings are also similar to those highlighted in a study conducted in Kenya in which it was reported that most providers had limited skills to attend to survivors of sexual abuse (Ajema *et al*., 2011). The healthcare provider capacity gap needs to be addressed by developing and rolling out specialised training modules on the management of child survivors of sexual abuse. This training should include modules on clinical management, forensic evidence management, psychosocial support, provision of prophylaxis and use of national documentation protocols. This study also suggests the need for such training to explore provider attitudes and values towards sexual abuse, and how these impact on service delivery. Counselling services presently available in health facilities are primarily designed for adults. This presents a challenge to providers who are required to attend to child survivors who comprise over 60 per cent of cases of sexual abuse attended to in Kenyan public health facilities. The findings of this study corroborate existing evidence which shows that when children report for healthcare, services are often not offered due to the lack of trained providers and equipment necessary for evidence collection and management (Keesbury and Askew, 2010). The incomplete documentation of services provided to child survivors makes it impossible to determine the quality of care provided. This gap should be addressed to ensure that survivors receive all the required prophylaxis and that health facilities maintain proper records to show the numbers of survivors who receive a comprehensive package of care. In this study, it was not possible to determine whether the missing data entries for prophylactic treatment (HIV, pregnancy prevention and STI management) referred to the lack of documentation despite services having been provided, or that the survivors actually never received the services.

**‘Provider capacity in the delivery of services to child survivors of abuse is critical’**

The inability of providers to collect samples from child survivors could be attributed to the lack of protocols for evidence collection as observed in a study conducted in Uganda where only one out of eight hospitals had standardised protocols (Henttonen *et al*., 2008). Findings of this study resonate with existing evidence (Wangamati *et al*., 2016; Welch and Mason, 2007), highlighting the need for facilities to be stocked with the requisite equipment, supplies and instructional material to aid providers in the collection and documentation of evidence.

**‘The inability of providers to collect samples from child survivors could be attributed to the lack of protocols for evidence collection’**

## Conclusion

This study highlights health system and service delivery gaps in the management of children who have experienced sexual abuse within public health facilities in Kenya. Training of providers is critical to enable them to



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offer comprehensive services to child survivors of sexual abuse. There exists the need to enhance child-centered service delivery approaches to facilitate the delivery of quality services to child survivors. In addition, the need for infrastructural modifications to allow for the setting up of child-friendly service delivery points in public health facilities exists.

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## Supporting Information

Additional supporting information may be found online in the Supporting Information section at the end of the article.