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Scoping Report

Feasibility of implementing AIDSFree guidelines to strengthen clinical and community linkages for child and adolescent survivors of sexual violence in Kenya

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List of Acronyms

4Children	Coordinating Comprehensive Care for Children
AAC	Area Advisory Council
AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adolescent living with HIV
CBO	Community-based organization
CHEW	Community Health Extension Worker
CHV	Community Health Volunteer
CPN	Child Protection Network
CRS	Catholic Relief Services
CSO	Civil society organization
DCS	Department of Children's Services
GBV	Gender-based violence
GVRC	Gender Violence Recovery Centre
HES	Household economic strengthening
HIV	Human Immunodeficiency Virus
INGO	International Nongovernmental Organization
IP	Implementing partner
IRC	International Rescue Committee
KII	Key informant interviews
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOU	Memorandum of Understanding
NCCS	National Council for Children's Services
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PSS	Psychosocial support
QI	Quality improvement
RCEA	Reformed Church of East Africa
SCO	Sub-County Children's Officer
SOP	Standard Operating Procedure
SV	Sexual violence
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAC	Violence against children
VACS	Violence Against Children Survey
VCO	Volunteer Children's Officer

Context and Scope of Work

This report summarizes the key findings and recommendations emerging from a scoping mission conducted in Kenya in August 2016. The overall objective of the mission was to gather information required to make a final decision on whether or not Kenya should be selected as a pilot country for 4Children's proposed piloting of the AIDSFree Companion Guide *Strengthening Linkages between Clinical and Social Services for Children and Adolescents who Have Experienced Sexual Violence*. A further objective, should the team recommend piloting in Kenya, is to provide the information required for designing and starting to operationalize the intervention with a specific focus on establishing referral pathways and improving community/clinical coordination for child and adolescent survivors of sexual violence.

The Companion Guide was drafted under the USAID-funded AIDSFree project, with inputs from a range of stakeholders, including those from Kenya. The guide provides a basic framework, examples, resources, and job aids for health providers and managers to better understand and facilitate linkages with critical social and community services for comprehensive care of children and adolescents who have experienced sexual violence.

This brief report provides an overview of the current policy and programming context, in relation to gender-based violence (GBV), sexual violence (SV), and violence against children (VAC) in Kenya and provides findings and recommendations around implementation options.

The scoping mission was conducted between 9 August and 16 August 2016 by Jennifer Casto (Encompass LLC and co-author of the Companion Guide) and Siân Long (Maestral International), with considerable support from Kelley Bunkers (4Children). The visit was hosted and facilitated by CRS Kenya.

Methodology

The following activities were undertaken:

- A pre-visit literature review of the sexual violence and VAC context in Kenya, drawing on more than 30 documents including national policies and guidelines and project documents from government and civil society partners. See Annex 1 for a list of documents reviewed.
- Key informant interviews with 30 informants, using interview guides tailored to four audiences: donor; government ministry; implementing partner; service delivery organizations. See Annex 2 for list of key informants. The interviews were conducted face to face, where possible, and by skype or telephone in some cases. The visit attempted to cover interviews with actors familiar with a number of regions of Kenya: Nairobi, Western, Coastal, Eastern, Rift Valley and Northern Arid Lands. Interview Guidelines are available upon request.
- Site visits in Turkana County and to the Gender Violence Recovery Centre at the Nairobi Women's Hospital.
- Out-briefing with USAID Kenya, at which preliminary findings were presented and potential areas for action were discussed. Key issues raised in the briefing are incorporated into this report.

This scoping study seeks to contribute to the overall findings of the proposed 4Children workplan for Kenya, to ensure that there is synergy between work on community-clinical linkages and other aspects of 4Children's technical work on children's vulnerability. [1]

[1] 4Children. *4Children Scoping Trip Report, May 2016.*

The rapid scoping mission led to some clear recommendations. However, should these recommendations be accepted, there will be a need for further detailed planning and budgeting discussions with selected key actors, especially those responsible for responding to the needs of children. The National Council for Children's Services (NCCS) acts as the multi-sectoral coordinating body while oversight of coordinated activities is allocated to the Department of Children's Services (DCS), which sits within the Ministry of East Africa Community, Labour and Social Protection. Key informants who are engaged in child protection and OVC work were all familiar with the coordination mechanisms and the NCCS's child protection implementation framework emphasizes the importance of a multi-sectoral approach. Complementary guidelines and frameworks also acknowledge the need for coordination; however, as with policy implementation, implementation of coordination mechanisms is also irregular.

It appeared, during this rapid scoping mission, that there are different ways in which coordination is being implemented, depending on who is available to support coordination at county or sub-county level. The scoping mission noted that Area Advisory Councils (AACs), which are mandated by the Children's Act and represent the NCCS at the local level, should be the coordinating body for all children's well-being issues, including child protection alongside other economic and social issues. The AAC is therefore a prime partner for coordinating clinic and community linkages – however, these groups are often dormant and do not play the planned role as coordinating mechanism, especially where international non-governmental organizations (INGOs) are working in parallel to government initiatives. One reason for this may be the lack of devolution of children's issues, unlike health and justice, for example. This means that, whilst a county and sub-county AAC officially has the mandate to coordinate children's activities, Department of Children's Services (DCS) staff are centrally appointed and not locally appointed, thus being often less known locally than AAC members who are locally selected.

As explained in the 4Children scoping report, children's issues were not devolved during recent government restructuring. The explanation given is that children's issues cut across many sectors and are considered a priority to addressat the national-level. However, this lack of devolution, in comparison to other discrete sectors such as health and education which are devolved, makes it more difficult for the DCS Children's Officers (COs) to work at county-level because of differing reporting levels, hindering functioning of the AAC and coordination between actors.[2] The lack of budget allocated to children's issues at county level – because children are a national issue – and a very limited national budget further constrain an effective response.

Despite these challenges, there were signs of strong local-level coordination, especially where stakeholders took the initiative (sometimes with INGO input) to form child protection networking and coordinating groups, such as the Child Protection Network in Turkana, Court Users Committees in several counties[3] and a Case Conferencing Committee in Busia. In Turkana, when the Child Protection Network members were asked about their role with the AAC, in relation to local government, the general feeling was that network members preferred to communicate directly with the County Assembly. Coordination is therefore varied across the country, according to local context, but in general understood as important. Coordination around children does need further focus, and

[2] 4Children. (2016). *Op cit.*

[3] The court-users committee is a recent initiative of the National Council Administration of Justice and seeks to address some of these issues. These committees are formed in locations where a court is located and involve COs, probation officers, police, NGOs, advocates, prosecutors, etc. who work to improve overall justice system response. There is also an effort to develop Children's Court Users Committees. Source: Key Informant interview, August 2016.

the Companion Guide could be used to stimulate such discussion by clearly focusing on health and child protection as a joint issue.

At local level, as also noted in the 4Children scoping mission report, there is good coordination of services– that is, referrals tend to be working well for some linkages. This does seem generally dependent on personal connections or in some cases on local well-functioning forums for child protection stakeholders. However, coordination is not consistent and a number of the mandated coordination bodies, notably Area Advisory Councils (AACs) appear to be weak. In Turkana County, for example, the well-functioning Child Protection Network appeared to generally act autonomously and bypass the AAC, linking directly with County Assembly members. In Busia, on the other hand, there appeared to be a much stronger coordination role by AAC. Much of this appears dependent on partner support at local level. The national Child Protection Framework recognizes the challenge of mandate, noting that: *"Poor linkages also cause problems during sector specific budget allocation. Other ministries, such as Education, local government, Health, Internal security, among others, find it difficult to allocate resources towards child protection, as their roles are not visible. Consequently, their collaboration is often based on goodwill, which contradicts the rights-based approach to child protection."*[4] The fact that there is recognition of the challenges, and the considerable effort that is being placed on enhancing linkages is a positive environment in which to introduce elements of the Companion Guide.

> *"The coordination process has allowed the DCS to have a lot of impact in coordinating their work at all levels. The amount of data they are collecting helps to show that people are understanding the process. There is an uptick of information collection and service delivery across stakeholders from different sectors."* Key informant, Nairobi

Clinic-community linkages require a strong link between formal and non-formal support mechanisms as emphasized in the Companion Guide. In Kenya, there is strong engagement of 'formal' non-government organizations, but service providers and local coordinators noted the challenges in getting the involvement of traditional and community mechanisms, particularly in relation to addressing the norms underlying sexual violence against children and adolescents.

SERVICES

The key services for child and adolescent survivors of sexual violence obviously include the health and psychosocial support aspects of immediate response. However, as outlined in the Companion Guide, there are a much wider range of community actors who play an important role. In Kenya, overall service provision for health is constrained but there is relatively wide coverage, especially for services related to HIV treatment and support. Kenya has a number of GBV interventions that offer promising models, discussed in sub-section 2a below. It is clear that the country has several well-functioning models of GBV care and these actors note that at least half of all clients are children and adolescents. In each of these clinics, there are strong links with the police and strong referrals *in* to the clinic.

> *"What we need is to have child protection structures at the community level because many of the cases are not coming out and being reported. The communities are very silent about these issues and people are afraid of the implications of bringing up these issues. There is a strong culture of handling the cases at the local level through traditional justice."* Key informant, Nairobi

[4] National Council for Children's Services. (2011). *The Framework for The National Child Protection System for Kenya.*

The different agencies are attempting to enhance coordination and some promising practices include:

- Active engagement in the county and local coordination mechanisms in Turkana County by the International Rescue Committee (IRC) Wellness Centre, enabling much wider awareness and participation in broader child protection issues;
- Capacity building, technical assistance, and referral network trainings for government and civil society organizations responding to GBV against children by the Gender Violence Recovery Center (GVRC); and
- Outreach training for Level II and Level III health facilities, through placement of a Ministry of Health (MOH) clinical officer within the Wellness Centre, who deals with all GBV cases in the county and has a role in capacity-building of all government health facilities.

The mission found that there was high awareness and referral into clinical services in cases of sexual violence when defined as 'defilement' – that is, rape. Other cases of sexual violence, including coerced early marriage, coerced or forced sex within relationships including age-disparate relationships, or sexual harassment and intimidation were not as commonly recognized as needing a response. Although the clinical services are not post-rape care, they are essential and include sexual and reproductive health care as well as interventions around sexual GBV prevention and response. The case of young female sex workers or the additional vulnerability of children and adolescents with disabilities were not commonly highlighted by key informants, but recognized as particular issues by Turkana Wellness Centre and ChildLine Kenya respectively. However, there exists far less clarity about what to do in terms of prevention and early identification within the community. This was particularly the case for some 'OVC' actors, including Local Implementing Partners (LIPs) for USAID projects such as APHIAplus. The number of sexual violence cases being picked up within local service provision were often quite low (six cases within a caseload of up to 10,000 children in one case). This does not tally with the overall burden and speaks to the need for additional sensitization.

A particular issue raised during interviews with stakeholders was the fact that sexual violence was not necessarily seen as an 'OVC issue', with limited knowledge about sexual violence amongst some of the Local Implementing Partners working on USAID-funded initiatives (although this is obviously a very rapid snapshot). One key informant noted that: *"It's not rampant in the areas we are serving; we have one case in a while."*[5] The informant noted that their focus was on awareness raising within the community and providing safe accommodation. Whilst this is clearly a protective and preventive response, there was a lack of the potentially much wider ranging issues of sexual violence.

WORKFORCE ISSUES

Community services for child and adolescent survivors are either provided through local NGO staff who are supporting volunteers, or through support to Community Health Volunteers /Community Health Extension Workers (CHV/CHEW) who report cases to clinics. The formal and informal sectors are both engaged in delivering services and there are a range of potential workforce cadres being supported to respond to sexual violence and who offer potential for modelling the Companion Guide.

Volunteer Children's Officers are highlighted in the Government of Kenya VAC National Response Plan of 2012 as central to early identification and post-violence response for children in the

[5] Key informant interview, August 2016.

community. They are described as "an integral link between the community and the existing network of child protection services".[6] As such, VCOs are local volunteers who are well placed to ensure that referrals between community and clinic for child survivors of sexual (and other forms of) violence are functioning for the benefit of the child. VCOs are able to provide counsel and support to survivors of violence and descalate potentially dangerous situations.

> *"We need demonstrative attitude change by all key partners – there are still people who believe that certain sections (police, judiciary, etc.) cannot provide good services. I want to see that change in belief so that people can go to the police, demand services and receive them."* Key informant, Nairobi

Although VCOs fall within the plans of the DCS and report to the county-level children's officers, currently there is very limited funding to support them. Lack of incentives and overall lack of VCO resources were acknowledged by several informants as a challenge. Nationally, the DCS noted the potential of building on CHEW experiences to identify what approaches can be replicated to help maintain VCOs.[7] In Busia in particular this cadre was receiving training and support from ChildLine Kenya and other partners. In other areas, where VCOs did not receive external support, local actors

Both CHVs/CHEWs and VCOs provide the entry point for strong community and clinic linkages; however, the scoping mission did not find examples of where these two cadres were working together for combined child protection and VAC interventions. This is an area where more could be done by combining community-level forces. Neither the MOH nor DCS noted this potential in interviews but it could be further explored at community level, by bringing in VCOs to health-facility GBV training and bringing in CHVs/CHEWs to child protection case conferencing, training and networking opportunities.

> *"There are still major gaps in terms of the justice system. There are no child-friendly services and children are forced to testify in front of the perpetrator, children are forced to miss school to attend court, court cases are often delayed several times which requires several trips to court for the child, magistrates have not been trained on how to work with child/adolescents in gender and especially those who are survivors of sexual violence."* Key informant, Nairobi

Linkages between the health sector and police were reported as being strong, in relation to referral from clinic to the police and judiciary. This is especially the case where there are gender desks in police stations. The most significant challenge, raised consistently by all informants working at service provision level, is the lack of accountability in relation to justice processes. Varied reports talk of the challenges in following through any justice processes with perpetrators and of a lack of child-centered justice. Whilst this is clearly a priority issue, it also requires a considerable level of engagement with the justice sector in country and may be too large and complex an issue to focus on within the proposed project. Several informants noted Court Users Committees, which were felt to be a valuable forum for fast-tracking individual cases of VAC.

There were fewer reported referrals from clinic to social welfare services than to police or court, despite the fact that County Children's Officers (CCOs) and Sub-County Children's Officers (SCOs) should be a point person for post-clinic support to child and adolescent survivors in the community. County and Sub-county Children's Officers were noted as being useful for individual cases requiring detailed engagement, but their workload and geographical remit is far too great to provide sufficient individual case management support to child and adolescent sexual violence survivors. In Busia and

[6] UNICEF, CDC, Together for Girls, & K. V. 2030. (2012). *Violence Against Children in Kenya: Summary Findings and Response Plan*.

[7] Key informant interview, August 2016.

Turkana Counties, Children's Officers were mentioned as important actors. In Busia, there is a concerted effort to scale up coverage and capacity of VCOs, through training provided by Childline Kenya (using their own training modules), provision of incentives and involvement of VCOs in local coordinating mechanisms.[8] However, other stakeholders were either not aware of the existence and importance of the role of CCOs and SCOs, or felt that they could not or would not participate in referrals. Some of this reflects the very clinic-bound approach of some initiatives.

The scoping mission did not have sufficient time to visit sites in sufficient depth or to fully explore perceived and actual roles of CCOs and SCOs, but any follow-up should identify a set of learning objectives around the potential for such actors playing a convening and quality assurance role for non-government actors.

The scoping mission did not allow for any assessment of technical quality of the response for child and adolescent survivors of sexual violence. In the specialist GBV clinics, stakeholders were following both national guidelines and their own adapted guidelines, and reported having a range of quality supervision and support in place. OVC actors appeared to know of referral guidelines and be confident about their reporting and referral of vulnerable children including, to a greater or lesser extent, children at risk of or experiencing sexual violence. The most significant flaw in the process, from a very rapid overview, was the social and child protection support to children once they were receiving clinical care. Informants at all sub-national levels talked of the importance of being able to put the child in a safe space, with limited knowledge of Kenya's alternative care guidance or of models of how to support children within their own communities – to address stigma and provide ongoing support in a way that does not rely on placing children in institutional care, risking long time and inappropriate placement in residential care facilities. In Busia there seemed to be few residential care facilities; in Turkana, actors used the Child Welfare Society's 'transitional center' which had a two-week limit after which children were sent to other residential care facilities. In Turkana, the Child Protection Network advocated for local government funding for a 'rescue center'. This may provide a safe space and transitional care, but may also run the risk of inappropriate placement in residential care. This is an area where the Companion Guide, with its focus on Best Interests Determination, could stimulate reflection on an improved response.

DATA AVAILABLE

Kenya was one of the first countries to have undertaken the Violence Against Children Surveys (VACS) and this data has provided stimulus at national level for the development of guidelines and standards operating procedures (SOPs) relating to child protection and sexual violence. However, there is less access to sexual GBV-focused data at an operational level. It is unclear what data is collected within health facilities about sexual violence, but there does not appear to be age-disaggregated data collated at clinic level and available nationally. There is currently no child protection information management system, although the DCS is receiving technical support for the development of a computerized tracking system for child protection cases and roll out is planned for the next several years.[9] This would provide invaluable data on sexual violence identification and referrals. Individual specialized clinics, such as the Wellness Center in Lodwar or the GVRC, do collect case data. Childline Kenya is a children's rights and protection NGO that operates the national Helpline and in 2015, project sites in Nairobi and Busia counties recorded a total of 2,534 calls, 316 or approximately 15% of these calls reported child abuse. Family members, neighbors, and other individuals known to the child or adolescent were the most common perpetrators. However, the

[8] Key informant interview, August 2016.
[9] Department of Children's Services (2016). CPMIS County Roll Out Guide 2016. Received from author.

lack of a routine and coordinated case management data collection system, comparable across counties or regions and lack of a mandated case management processes, constrains an effective response.

POTENTIAL MODELS AND PARTNERS

The scoping mission identified a number of potentially interesting models or approaches that could serve as sites for piloting the Companion Guide and there was a lot of interest from stakeholders for using elements of the Companion Guide to improve the local and national response for child and adolescent survivors of sexual violence. The observations below, however, must be viewed in the context of a very rapid assessment and any further consideration would need to further examine the models.

The criteria used by the consultants to show what is a 'promising' model or approach, that could effectively serve as a pilot opportunity for the Companion Guide is as follows:

- Fitting within, and enhancing, the national framework of gender-equitable, rights-based approaches to children and adolescents at risk of or surviving sexual violence;
- Focus on building up capacity of local actors and strengthening the health and social welfare workforce;
- Where there are already coordination and networking mechanisms that bring together key actors, and that include community level initiatives and/or having investment in community-level outreach and support for child and adolescent survivors of sexual violence – for example, chiefs, schools, etc.;
- Mobilizing resources, locally through decentralized government or through sharing and maximizing available resources;
- Generating evidence on what works and commitment to advocating for scale up within government-led responses; and
- Having a lead implementing partner with experience in both child protection and sexual violence.

Some of these promising models and approaches are described in the text box below:

Turkana County Child Protection Network / Wellness Centre: In Turkana County, there is a close working relationship between the Child Protection Network (CPN) and IRC-supported Wellness Centre.

The CPN has more than 20 partners, representing county government, education, health, community-based organizations (CBOs), faith-based organizations, and individuals. It is co-chaired by the County Children's Officer and a rotating co-chair selected from local civil society organizations. The current co-chair is ChildFund Kenya. The DCS is the permanent secretariat and the co-chair contributes to hosting regular meetings. The CPN monthly meetings are a forum for sharing, working together and referrals where necessary. The CPN has developed their terms of reference and are currently finalizing a five-year strategic plan, which is shortly to be validated and presented to County Parliament. The CPN gets some support from UNICEF. Although the CPN is officially a sub-committee of AAC, they do not appear to link with the AAC, rather going directly to County Government. The CPN have already successfully mobilized local budget allocation from County Government, for building a children's rescue center. Active members who provide a level of resourcing and technical support include the Catholic Diocese's Child Protection program (with *Terres des Hommes* support), ChildFund and a national legal aid NGO, the Cradle.

The **Wellness Centre** is an IRC-supported health center based at the Turkana Referral Hospital. The center provides medical and psychosocial support (PSS) to survivors of GBV and key populations. The County medical officer responsible for GBV is based in the Wellness Centre and provides training to Level II and Level III health facilities in the county on GBV, with an ongoing capacity-building role. The Wellness Centre is well positioned to provide services (health, PSS and referrals) to especially vulnerable women and children as well as act as a referral point for OVC, and especially for children of key populations. In particular, referrals to services providing legal aid, nutrition support, support groups, and household economic strengthening initiatives were identified as important services for linkages. The Centre is an active member of the CPN. IRC is supporting the development of an improved GBV desk at Lodwar police station as part of a focus on improving the police and justice roles.

ChildLine Kenya is a national children's rights and protection NGO that runs the well-established national helpline for children ('116'), on behalf of the government and guided by a Memorandum of Understanding (MOU), and a range of community-based programs. Amongst other programs, the Family Based Care Program (implemented in Coastal, Kisumu (Busia) and Dagoretti) includes a focus on ending VAC in the context of strengthening community-based and family-based alternative care. The project is in partnership with Save the Children. Related projects focus on peer education around sexual and reproductive health and rights in schools, providing linkages between school peer educators and others supporting vulnerable children, and on positive parenting. ChildLine also works with community groups, including the ten-household government Makumi Initiative groups, providing a link with community structures at the lowest level. Disability is one focus of the work.

ChildLine in Busia developed a child protection case management/referral document (based on Child Helpline International) initially to enable local coordination. This document has now been passed to the NCCS to make it a national document. ChildLine supported the NCCS to validate the tools and ensured involvement of children and adolescents. The tools continue to be used in Western region. They are working closely with Sub-county and County Children's Officers and help convene a Sub-county Case Conferencing Committee, using the case management tools and working together on capacity building. They are training and supporting VCOs to be a focal point in the community. ChildLine is also working with the DCS to develop a child protection management information system. ChildLine in Busia and elsewhere have undertaken a number of activities that are set out as key steps for strengthening clinic and community linkages in the Companion Guide: working in partnership with local government and civil society organizations (CSOs), mapping local service providers, and coordinating clinical, government, and community stakeholders to respond to cases of sexual violence against children and adolescents.

The ChildLine key informants were aware of the importance of key approaches, in particular in relation to best interests determination, child participation and accountability.

In Kilifi, VCOs are reportedly using a mobile SMS system called **Virunga Mapa** (sponsored by Plan) to notify police, clinic officers, MOH, etc. when they discover a case of child abuse or sexual violence at the community level. This helps to ensure a more rapid and coordinated response. The scoping mission did not manage to get information on this system but it could be further explored at initial development stages of the project. Other places that may be interesting to know more about are Nakuru and Magori and Homa Bay in Western.

UNICEF and Plan support Child Protection Centers in Kilifi, Nakuru, and Garissa. These are one-stop centers operated in conjunction with the Kenyan government to provide co-located multi-sectoral

child protection services that include, but are not limited to, response to sexual violence. The CPCs provide initial medical and legal support in the short-term and psychosocial support in the long-term. The CPCs do not necessarily provide linkages with community services for the purposes of reintegration of child and adolescent survivors but these centers could be a potential convening organization for linking clinical and community services and developing referral networks. The CPCs also operate rescue centers with a 3 month maximum stay.

Gender Violence Recovery Centre (GVRC) could be utilized as a training partner for capacity building and referral network establishment if appropriate for the pilot. They have technical expertise in this subject, understand the local context, and have extensive training experience. They have trained implementing partners, CSO, government partners, and local level coordinating committees such as AACs specifically on referral networks.

At national level, **Plan, UNICEF, International Rescue Committee and Childline Kenya** are among the strongest potential partner organizations in terms of technical knowledge of SV against children and adolescents.

Conclusions of the scoping mission

The purpose of this scoping mission was to assess whether the Companion Guide would be a useful tool to enhance existing practice in Kenya. The scoping mission found that Kenya would be an excellent country in which to explore piloting of elements of the Companion Guide, as summarized below.

Sexual violence against children and adolescents is high, with relatively robust evidence at national and some local levels and overall policy and stakeholder consensus that the issue requires action.

Service access and provision remain limited and gender norms and other social norms, including stigma, inhibit children's access to information about sexual violence prevention and support. There is a substantial need for community-based support to child and adolescent survivors of sexual violence, that can provide both essential post-clinic follow up and (equally if not more important) ensure effective prevention and early identification. Community-based interventions that can most effectively address underlying drivers of sexual violence against children and adolescents are needed.

Policies and accompanying SOPs and guidelines recognize and seek to both prevent and respond effectively for survivors of sexual violence, including child and adolescent survivors, offering a conducive policy environment. However, there remains a gap between policy framework and implementation on the ground.

National stakeholders acknowledge the gaps in current policy and ***there are some timely opportunities for applying lessons from the Companion Guide into existing government-led initiatives***. In particular, the imminent DCS introduction of case management and referral guidelines, for use by all actors involved in child protection, is a key opportunity to strengthen clinic-community linkages. The Companion Guide outlines clear steps for establishing and maintaining referral networks, and this guidance could be beneficial for the roll-out of the DCS case management and referral guidelines. Furthermore, current Ministry of Health management of sexual violence guidelines are relatively old and are acknowledged by gender mainstreaming MOH representatives to have insufficient focus on children and adolescents or on post-clinic referral. The MOH is interested in possibly updating their guidelines.

There is ***widespread interest amongst OVC, GBV and child protection actors for enhancing clinic to community linkages***. A number of projects offer entry points for exploring elements of the Companion Guide, and actors have all expressed interest in the potential use of the tool within their existing approaches, to enhance what they are already doing. The potential models are described above. The recommendations below spell out the criteria and rationale for recommended suggestions but there are a wide number of potential opportunities for further exploration.

Recommendations

The recommendations below are aligned to the 2012 Government of Kenya VAC Response Plan.[10] They endorse the overall foundational approach of the plan to have a fully realized child protection system at all levels in the country.

The VAC Response Plan requires analysis of these four areas:

1. legislative and policy issues
2. quality and availability of services
3. coordination of child protection sector
4. circumstances in which violence occurs

Any pilot activity should take these four areas into consideration during design and implementation to ensure alignment with the VAC response priorities of the Kenyan government.

a. 'Model' the Companion Guide in Kenya in two sites plus a national component

The current 4Children work plan proposes piloting in two countries. We propose that the resources available for this work are better invested in one country, working in two different sites with a national component. This would be a more effective use of resources, with no further scoping costs and would maximize learning in one country. There is sufficient variety in the Kenyan context to offer some valuable lessons. There is a conducive environment in terms of government and local partner buy-in and the findings can be translated into the ongoing VAC Response Plan as implemented by Government of Kenya.

The term 'modelling' is preferred to piloting. Modelling suggests using elements from the Companion Guide, to demonstrate good practices. This is preferred to the idea of piloting, which suggests using all aspects of the companion guide and starting from scratch with a new initiative or stand-alone project. The proposed approach is to pick elements from the Companion Guide to embed within existing initiatives, rather than a whole new pilot.

The suggestion is to focus on two different areas, with differing approaches, plus some activity at national level. The main focus would be to focus on Section 6 of the Companion Guide, on Referral Pathways and Community /Clinical Coordination.

If this recommendation is accepted, a preliminary recommendation would be:

- Turkana County, working with the Child Protection Network and IRC's Wellness Centre to explore how to expand reach of the Wellness Centre and improve linkages with community organizations and activities working to respond to child and adolescent survivors – this site offers a functioning network with strong technical expertise and a context of rapid urbanization (Lodwar), new mining areas (Turkana South), fishing and migrant labor (Lake

[10] UNICEF, CDC, Together for Girls, & K. V. 2030. (2012). *Violence Against Children in Kenya: Summary Findings and Response Plan*.

Turkana) and refugees (Kakuma) and experience of leveraging local resources through devolved government;

- Childline Kenya, with partners, in Busia County (provisionally) or elsewhere in Western Region, to strengthen the AAC's Case Conferencing Committee's linkages with clinical and community services and focus on integrating sexual violence identification, prevention and response within the emerging case management approaches and sexual and reproductive health initiatives that are underway – this site experiencing high levels of sexual violence due to cultural practices, fishing trade (Lake Victoria), heavily HIV-impacted communities, and an already functioning case management system actively led by Children's Officers; and
- A third possibility could be Coastal region, possibly Kilifi, to work with the UNICEF- and Plan-supported Child Protection Centre who function as one stop centers and are potentially a referral hub, and the fact that there are VCOs being supported to refer children into and out of services.

A network analysis in the proposed two locations is a necessary first step in determining exactly which elements of the guide should be piloted, by determining which stage they are at in the steps outlined in Section 6. Having done this, the modelling exercise could move towards formalization of the networks as outlined in the Guide. This could be done through a network audit/assessment using the Companion Guide tools, in order to help them formalize and strengthen their existing referral networks, in line with the national VAC Response Plan.

b. Use the Companion Guide to explore key accountability requirements and potential mechanisms for referrals and case management at operational level

As outlined in the Companion Guide, accountability is an important aspect of establishing referral networks and improving community/clinical linkages. The current referral and service delivery processes work well where individuals coordinate well together. However, key informants noted challenges in relation to standardized and enforceable accountability – both mutual accountability and self-accountability. One common set of questions would be to assess the current and desired referral processes and identify what monitoring, evaluation, and accountability mechanisms would be most appropriate. The proposed sites for modelling already have functioning coordination mechanisms that can benefit from improved accountability that, once successfully piloted, can be shared with other sites to build referral network trust and collaboration. Examples of how to do this include:

- exploring who is the case manager from clinic through to community, and what level of responsibility do they have to enforce accountability;
- use of standard referral forms across stakeholders to coordinate and track response to cases of sexual violence against children and adolescents;
- developing Memorandums of Understanding (MOUs) locally that work and are in line with national SOPs and guidance; and
- Identifying what makes an effective shared case conferencing process.

This recommendation would feed into the VAC Response Plan action point of: Quality & Availability of Services: Evolving the GOK's community strategy for engaging the health sector in the protection, promotion, prevention, early identification of and referral to services for children who experience violence.

c. Document how the Companion Guide could be adapted for different local contexts, based on existing models, referral systems, and case management approaches

The proposed sites use different types of referral networks and have differing relationships with statutory bodies, such as Child Protection Networks and Committees, County and Sub-County AACs, etc. The settings are also different, with sparsely and more densely populated settings, different cultural practices, and different levels of urbanization. The Companion Guide consciously works on the principle that there is no one 'best' model and that things must be adapted for the local context in order to be successful. However, documentation could identify some areas of standard guidance that ensure quality and consistency of services and strength of referral networks. The pilot sites should set out some common learning objectives.

This recommendation would feed into the VAC Response Plan areas of both service quality and coordination. In particular, the Coordination aspects are aligned with the following action points from the Plan:

- Establish coordination mechanism that provides guidance to non-government actors about proper reporting procedures and monitoring techniques;
- Systemize response mechanism to coordinate and align children's activities into county government plans and programs;
- Develop strategic and transparent partnerships and networks to support children's programs, and link with existing programming in HIV/AIDS and other health issues;
- Develop framework for community and county level referral networks to increase access to essential services for children and for households.

Should the recommendations above be accepted, the following points could be explored further in terms of finalizing a budgeted implementation plan:

d. Invest resources at national level to enhance national oversight and include sexual violence within the proposed national case management framework

The national component would assist the DCS to operationalize the case management guidelines, with a focus on strengthening the clinic-community linkages in terms of response for child and adolescent SV survivors. The key partner should be the NCCS, through the DCS. Further discussions should be held with both DCS and the MOH, especially the gender mainstreaming unit and also adolescent and sexual and reproductive health policy makers. At the moment, there does not appear to be much coordination between the DCS and the MOH at the national level regarding response to sexual violence against children/adolescents. This lack of coordination may trickle down to the local level and result in uncoordinated or duplicative efforts.

The national level discussions should focus on:

- priority SOPs and guidance that could be updated based on lessons learned in piloting;
- identifying prevention and early identification approaches that address the underlying drivers of sexual violence, including issues such as gender norms, child marriage, migration, household economic coping mechanisms, etc.;
- reviewing the draft case management tools developed by ChildLine Kenya, to check that sexual violence issues are reflected, explore how to ensure that the right people are using them and that key mechanisms identified as important for SV clinic to community linkages (e.g. Case Conferencing Committee and Court Users Committee) are integral to the referral process; and

- Focus on collaboration with police and court users committees – this is probably the best entry point for the referral networks to access and hold the justice system accountable.

e. Add greater focus on children and community referrals within the Ministry of Health sexual violence management guidelines

There are no plans for currently reviewing these guidelines, but they are currently quite old and MOH informants were interested in potentially updating the guidelines as they are aware that the focus on child and adolescent survivors is limited. The Turkana Wellness Centre uses a combination of government guidelines and IRC's guidelines.[11] Other centers, such as those in Coastal Region, reportedly also have their own guidelines. This may be an area for further discussion.

f. Use the Companion Guide to enhance early identification and prevention within a child protection and GBV approach

Although response mechanisms are known and there is clarity about what to do in cases of 'defilement' or rape (generally), there is less known about how to ensure early identification. Prevention and early identification are priority action points within the Government of Kenya's National Response Plan of 2012.

The two proposed modeling sites could focus on the biggest recognized gap – linkages with community-level traditional mechanisms of child protection and working with traditional and community leaders to generate awareness on prevention and early identification of sexual violence. This topic can be integrated into existing referral networks during the Companion Guide modeling.

USAID PEPFAR partners, especially those working with OVC, are a potential target group for training on SV early identification and prevention, given the limited awareness of sexual violence amongst some partners.

g. Ensure that responses to and services for child and adolescent survivors of sexual violence are in the best interests of the child, especially in relation to alternative care, with a focus on child participation

The Companion Guide includes sections that focus on best interest determination and models for child participation. Both issues have been highlighted as priority areas for improvement by informants. If both potential project sites could work through some of the issues, identify innovations in both areas, and identify ways in which to monitor improvements in integrating the voice and priorities of children and adolescents, this would provide valuable lessons for others.

One way in which this could be done would be to promote tools (media briefings, interviews, blogs, pamphlets, for example) developed by and/or with child and adolescent survivors of sexual violence. Areas of focus could be:

- documentation of a children's own definition of sexual violence, moving beyond issues such as 'defilement' to more girl- and boy-centered descriptions of coercion, pressure and power;
- what is best in the long run for a child living in the context of limited formal resources and strong community and family structures and cultures, using the alternative care framework and sexual and reproductive health guidance as a framework to build upon; and

[11] International Rescue Committee. (2008). *Clinical Care for Sexual Assault Survivors: A Multi-media Tool. Facilitator's Guide.*

- Exploring how children's voices could best be heard through the clinic to community case management process.

h. Ensure identification of and support for child and adolescent key populations

The scoping mission was not able to fully explore the extent to which children and adults who are highly vulnerable to sexual violence exposure are being assisted in existing initiatives. These include child and adolescent sex workers, children of female sex workers, men who have sex with men (MSM) and drug users, alongside other marginalized children and adolescents, such as children living in fishing communities. The Wellness Centre in Lodwar has an outreach program with sex workers and there are a number of national networks of young MSM and sex workers.

In both Western region and Lodwar, mobility is high and increasing and there are high rates of poverty. Any modelling should ensure an active input from actors who can identify the highest levels of vulnerability. The Companion Guide offers tools to explore vulnerability. When referral networks are formalizing and using Companion Guide tools, they should be assisted to think through how they can best respond to the different needs of these key populations.

Annex 1: Bibliography

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Annex 2: List of key informants

No.	Name	Organization	Location
1	Wilfrida Achuman	Social Worker, Child Welfare Society	Turkana County
2	Beryl Arogo	Gender Violence Recovery Centre	Nairobi
3	Joseph Baraza	Gender Mainstreaming Department, Ministry of Health	Nairobi
4	Mercy Chenge	Child Protection Officer, Plan International	Nairobi
5	Eunice Cherire	Gender Mainstreaming Department, Ministry of Health	Nairobi
6	Pius Ekidor	Watoto Wazima Initiative (WWI)	Turkana County
7	Michelle Ell	Deputy Chief of Party, USAID/Nilinde Program	Mombasa
8	Phibia Erot	IRC, Wellness Centre, Lodwar	Turkana
9	Rebecca Gitau	Gender Violence Recovery Centre	Nairobi
10	Rudia Ikamati	Aphiaplus Kamili	Kamili, Eastern & Central Regions
11	Dr.Hannah Kagiri	Gender Mainstreaming Department, Ministry of Health	Nairobi
12	Catherine Kimotho	Child Protection Team, UNICEF Kenya	Nairobi
13	Charity Kosgei	Sub-County Children's Officer, Turkana South	Turkana County
14	Geoffrey Luttah	International Rescue Commitee	Nairobi
15	Joyce Mathuuri	Gender Mainstreaming Department, Ministry of Health	Nairobi
16	Moses Simiyu Mateyi	Project Officer, Childline Kenya	Busia, Western Kenya
17	Mariam Mbebe	PATH	Western Kenya
18	Frederick Mutinda	Child Protection, CRS Kenya	Nairobi
18	Eric Gitau	Child Protection Team, UNICEF Kenya	Nairobi
19	Marygorret Mogaka	Assistant Director, Field Operations, DCS	Nairobi
20	Rose Mwongera	Gender Mainstreaming Department, Ministry of Health	Nairobi
21	Wariara Muko	Advocacy Officer for HIV, TB and SGBV, MSF	Nairobi
22	Brenta Muli	Field Operations, DCS	Nairobi
23	Evans Munga	Childline Kenya	Nairobi
24	Fenny Mwemuye	Project Manager, CRS	Garissa
25	Noah Sanganyi	Director, DCS	Nairobi
26	John Wafula	Child Protection Team, UNICEF Kenya	Nairobi
27	Elim Walanyang	Program Officer, Childfund / Co Chair, Turkana Child Protection Network	Turkana County
28	Jeannette Wijnants	Director, Child Protection Team, UNICEF Kenya	Nairobi
29	Dr. Ben XXX	County medical officer for SGBV	Turkana