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Lessons from Kenya and Uganda

STRENGTHENING REFERRAL PATHWAYS FOR CHILDREN AND ADOLESCENTS AFFECTED BY SEXUAL VIOLENCE

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Authors

Isabel de Bruin Cardoso with input from Siân Long

Reviewers

Tom Ventimiglia, Doreen Alaro, Daniel Oloo, Thomas Fenn

Cover photo

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Introduction and Global Context

Violence against children affects all children, regardless of age, gender, ability, race, economic status or living arrangement. It affects children living in family-based care, as well as those living outside of parental care, in high-, middle- and low-income countries and in stable and humanitarian contexts. Evidence shows that globally up to one billion children are affected by violence each year.¹ Across Africa, at least 50% of children between the ages of 2 and 17 years have experienced one or more forms of violence (excluding spanking, slapping and shaking) in all settings.² It affects the well-being of individuals, families and communities, and is considered a major global public health problem, that can cost States an average of 5% of GDP.³

Violence against children exists in many different forms, including physical, psychological and sexual violence. The majority of countries across the globe have criminalized sexual violence against children, with an increasing number of countries criminalizing physical violence, including corporal punishment. A criminal act legally requires that a violation is reported, and that all steps are taken to ensure the case is investigated and, if confirmed, justice is served. However, despite the laws being in place, there is still limited evidence-informed guidance regarding how to ensure an effective and comprehensive response to sexual violence against children.

It is widely understood that children affected by sexual violence should access core health and social welfare support, and that a case is built that can be referred to the justice system — all of which require a strong referral pathway within and across sectors. The importance of an integrated approach is highlighted in the 2016 INSPIRE package, which sets out seven evidence-informed strategies to support countries and communities to intensify prevention programmes and services to reduce violence against children.⁴ A related implementation handbook has recently been developed to provide practical guidance to implementing the strategies.⁵ The INSPIRE package and implementation handbook stress the importance of referrals and coordination. However, there remains limited evidence as to how such a referral pathway can be effective and efficient in practice.

AIDSFree Companion Guide

In order to address this gap, in 2016 AIDSFree developed [Strengthening Linkages between Clinical and Social Services for Children and Adolescents Who Have Experienced Sexual Violence: A Companion Guide](#) (hereafter, Companion Guide).⁶

The Companion Guide was developed initially to complement USAID's 2013 Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs.⁷ This document focused on clinical/forensic management and did not address in detail how providers can better understand and facilitate linkages with critical social and community services for comprehensive care for children and adolescents who have experienced sexual violence and exploitation. The Companion Guide was therefore developed with the aim of generating understanding and strengthening capacities of clinical and community services to facilitate linkages as a means to providing comprehensive care for children and adolescents who have experienced sexual violence and exploitation.

The guide provides the basic framework, examples, resources and job aids for health and social service 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;
- take additional steps to help children and adolescents receive information and support their needs;
- contribute to changes in sociocultural norms that perpetuate a culture of violence and silence that can increase HIV risk and vulnerability.

The Companion Guide drew on the practical experiences, and promising guidelines and resources, from a wide range of organizations and programs that were implementing various aspects of this work. The Companion Guide is intended as a general resource for adaptation to country-specific contexts, resources, needs, laws and policies. To explore whether and how far the Companion Guide can be used as a resource for more local application, 4Children was asked to conduct two small-scale activities. This report summarizes the experiences of these two activities and some overall considerations on how the Companion Guide can be used locally.⁸

COMPANION GUIDE CONTENTS

The Companion Guide is organized into sections that provide an overview of the key issues related to the intersection of sexual violence and HIV and the various integrated, comprehensive models that are currently provided. A summary of the minimum services needed by child and adolescent survivors of sexual violence and exploitation provides an overview of key considerations, along with a

1 Hillis, S., Mercy, J., Amobi, A., Kress, H. Global prevalence of past-year violence against children: A systematic review and minimum estimates. *Pediatrics* 2016;137 (3): e20154079. This study defines violence to include exposure to one or more types of victimization (physical, sexual or emotional) committed by a range of perpetrators (authority figures, peers, romantic partners or strangers) in various locations (home, school or community).

2 *Ibid.*

3 Hsaio, C., Fry, D., Ward, C. et. al Violence against children in South Africa: the cost of inaction to society and the economy. *BMJ Global Health*, 2018; 3

4 World Health Organization (2016). INSPIRE: seven strategies for ending violence against children. http://www.who.int/violence_injury_prevention/violence/inspire/en/

5 World Health Organization (2018). INSPIRE Handbook: action for implementing the seven strategies for ending violence against children, pages 200-201. <http://apps.who.int/iris/bitstream/handle/10665/272996/9789241514095-eng.pdf?ua=1>

6 Levy, M., Messner, L., Duffy, M., Casto, J. (2016). Strengthening Linkages Between Clinical and Social/Community Services for Children and Adolescents Who Have Experienced Sexual Violence: A Companion Guide. Arlington, VA: Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project. <https://aidsfree.usaid.gov/resources/prc-companion-guide>

7 Day, K. & Pierce-Weeks, J. (2013). The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs. https://aidsfree.usaid.gov/sites/default/files/prc_english.pdf

8 As noted above, since the inception of these activities, WHO's INSPIRE implementation manual has been developed. The findings in this report should be seen as a focus on the "Response and Support" section of INSPIRE

checklist of recommended starting points and aspirational standards. Sections address the roles and responsibilities of each cadre that forms a part of the overall response system, an overview of mandatory reporting and how to reconcile this with the child's/adolescent's best interests, a section on referral pathways and community/facility coordination and an overview of important case management processes. The guidance concludes with an overview of principles, guidance on how to ensure standards of care designed to benefit the child's/adolescent's health and well-being, and a brief overview of seven case study programs.

MODELING THE AIDS-FREE COMPANION GUIDE IN KENYA AND UGANDA

4Children undertook a scoping visit to **Kenya** in August 2016 to gauge the feasibility of piloting the Companion Guide.⁹ The team observed that there is a widespread need to enhance clinic and community linkages to respond to the high rates of sexual violence against children and adolescents, and that there is interest among key actors (OVC, GBV and child protection) to apply the Companion Guide within existing approaches.¹⁰ The scoping visit proposed various entry points, all aimed at strengthening the referral system for children and adolescents who have experienced sexual violence, to ensure their access to critical short- and long-term medical, psychosocial, safety/protection, legal/justice and other social services. The recommendations were aligned to the 2012 Government of Kenya Violence Against Children (VAC) Response Plan.¹¹

“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 a local level through traditional justice”

—Key informant, Nairobi

In **Uganda**, a scoping visit was not formally conducted. 4Children's existing engagement with the Ministry of Gender, Labour and Social Development (MGLSD) supporting the strengthening and harmonizing of tools for OVC case management facilitated an assessment of priorities. Through the engagement on national case management, stakeholders noted specific and significant challenges around referrals, particularly with respect to strengthening referrals between clinical and community partners. It was therefore decided, and agreed with MGLSD and other stakeholders, to bring together four neighboring districts from Central Region to work collaboratively and identify bottlenecks to referrals and coordination. Subsequently, using the Companion Guide as a practical tool to stimulate discussion about existing

government guidelines and together with civil society and statutory actors, the focus can turn to practical solutions.

Country Context

In both Kenya and Uganda, available data on violence against children (see Figure 1 on the following page) shows the extremely high scale of prevalence, as well as the challenges to and the urgency of responding effectively and comprehensively to child and adolescent survivors of violence.

In Kenya, around one in three girls (32%) and almost one in five boys (18%) reported having experienced sexual violence in 2010. In Uganda, more than one in three girls (35.3%) and around one in six boys (16.5%) reported experiencing sexual abuse. As the chart/diagram below illustrates, despite very high levels of experience, the number of children who feel able to tell someone, report their experiences to services, and receive services dramatically drops off, for example, less than one in 200 boys in Kenya who experienced sexual abuse receiving services.

In both Kenya and Uganda, data generated by the VACS have provided a stimulus at national levels for the development of guidelines and standard operating procedures (SOPs) relating to child protection and sexual violence. In Kenya, the preexisting Kenya National Guidelines on Management of Sexual Violence (2009) recognizes sexual violence as a “cross-cutting issue, and no one authority, organization or agency alone possesses the knowledge, skills, resources or mandate to respond to the complex needs of the survivors or to tackle the task of preventing violence against women and girls.”¹² These guidelines also emphasize the need for multidisciplinary collaboration around prevention and response to sexual violence. The National Standard Operating Procedures for the Management of Sexual Violence Against Children (2018) recognizes the importance of a “strong protection and referral network to ensuring that the care provided is comprehensive, response and addresses both short and long-term recovery needs of the child,”¹³ and highlights the core components of a comprehensive coordinated response to SGBV against children.

As in Kenya, the Government of Uganda has developed and is implementing several strategies that directly promote interventions related to Violence Against Children, such as the [National Strategic Plan on Violence Against Children in Schools 2015-2020](#), the [National Strategy to End Child Marriage and Teenage Pregnancy 2014/5-2019/20](#), and the [Children Act Amendment 2016](#). These strategies, frameworks and plans are encouraging and demonstrate that both political will and engagement exist to address violence against children.

An important entry point for piloting the Companion Guide was to build on the national commitment to **case management** for the protection of children. This provided an opportunity

9 4Children (August 2016). Scoping report: Feasibility of implementing AIDS-Free guidelines to strengthen clinical and community linkages for child and adolescent survivors of sexual violence in Kenya.

10 *Ibid.*

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

12 Government of Kenya, Ministry of Health (2009). Kenya National Guidelines on Management of Sexual Violence.

13 Government of Kenya, Ministry of Health (2018). National Standard Operation Procedures for Management of Sexual Violence against Children, p. 20.

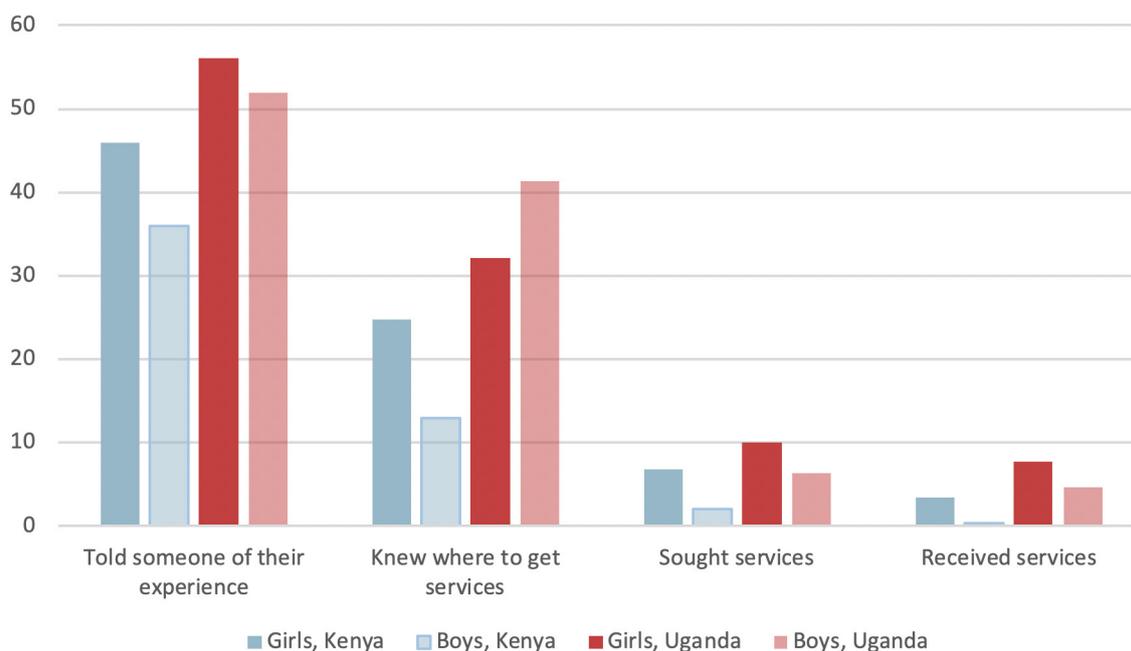


Figure 1. Children's sexual violence experiences (%); Kenya and Uganda VACS data.

to bring clinical and community actors together with already available tools. In **Kenya**, a child protection information management system was launched nationally in 2017; this computerized system for child protection cases will provide invaluable data on sexual violence identification and referrals to increase the evidence base at an operational level. In **Uganda**, national standardized case management tools, standard operating procedures and a training guide have been developed by the Ministry of Gender, Labour and Social Development through a consultative approach with child protection actors and with support from 4Children. This is an ongoing process, with anticipation that the end journey will promote a shared language, understanding and practice of case management by all Government of Uganda and civil society actors.

However, there are challenges that continue to impede an effective joined-up response. In Kenya, the 2018 National Standard Operating Procedures for the Management of Sexual Violence Against Children promotes a multifaceted response, including providing referrals for medical treatment, HIV testing and counseling, psycho-social support and legal services to all survivors. However, the SOPs do not set out sustainable referral and linkage pathways, nor do they provide guidance regarding how these services can best cooperate to coordinate referrals. Apart from health facilities being encouraged to “forge good relationships with the children’s department, police and other relevant service providers,”¹⁴ there is little concrete guidance as to how this can be done, and what role other service providers can play in strengthening such relationships to ensure a functioning referral pathway. In Uganda, likewise, no national document sets out a framework for referrals or coordination, and limited practical tools exist that oblige different actors to meet and work together to ensure consistent follow-up in cases of violence.

APPROACH

In both countries, the initial approach was to initiate consultation with the lead ministry in charge of child protection. In both countries, stakeholder feedback focused primarily on seeing how there could be practical guidance for referrals and coordination.

In **Kenya**, the Department of Children’s Services (DCS) at the Ministry of Labour and Social Services was consulted to gauge interest in piloting (aspects of) the Companion Guide. Clear interest was shown, particularly with respect to the envisaged lessons and outputs being able to inform finalization, pilot and roll out of the National Case Management and Referral Pathway Guidelines.¹⁵ Seeing that the development of these guidelines was being facilitated by DCS, it was agreed that DCS would take leadership in modeling the Companion Guide to ensure linkages between the two processes.

In order to oversee the project approach, a national Technical Working Group (TWG) was established, which included key actors involved in the response to children affected by sexual violence: Department of Children’s Services (DCS) at the Ministry of Labour and Social Services, Ministry of Health, Child Helpline, Gender Recovery Unit at the Nairobi Women’s Hospital, International Rescue Committee, UNICEF and Catholic Relief Services. The TWG was led by DCS, which facilitated a multisectoral workshop to develop an action plan for piloting the Companion Guide that focused on:

- Mapping statutory and community structures preventing and responding to SGBV;
- Trainings at the county level on how referral pathways can be strengthened.

14 *Op. cit.*

15 The finalization and pilot of the National Child Protection Case Management and Referral Pathway Guidelines was underway when the initial discussions around modelling the Companion Guide started in April 2017. The process has been delayed, but lessons from the model still remain applicable and relevant.

The Companion Guide was modeled in two counties (Turkana and Nakuru), and reached a total of 199 participants, including representatives from health, social welfare, child protection, police and justice sectors. These counties were identified in agreement with the TWG based on the following characteristics:

- higher than national average HIV prevalence rate; availability of sexual and gender-based violence specific services;¹⁶
- availability of key cross-sectoral and interagency networks with strong technical expertise;
- emerging case management approaches as a result of piloting the National Case Management and Referral Guidelines in Nakuru.

Participatory workshops were facilitated by county-level DCS representatives, together with 4Children, in two meetings

per county. The workshops aimed to improve bidirectional referrals to improving linkages between community services, clinical support and the justice system, in order to inform the finalization of the National Case Management and Referral Guidelines. Key participants included representatives from DCS, health, police, probation, National Gender & Equality Commission, education, labor, justice and civil society. It was considered to be more effective to have county-specific meetings, rather than bringing participants to a joint meeting, due to the counties' differing contexts (e.g., urban vs. rural, population density, literacy rates), resources, availability and range of service provides, all which impact on the tools used and processes applied in the referral pathway.

In both counties, participants initially visualized the current referral pathway being used in that county, using the checklist offered by the Companion Guide (see Checklist below), to identify how referrals could be strengthened. This was followed by a discussion on roles and coordination

CHECKLIST—ESSENTIAL ELEMENTS FOR BRIDGING COMMUNITY-FACILITY STAKEHOLDERS

(Companion Guide, p. 43)

Step 1: Start with community mapping

Conduct community mapping of potential referral points that provide relevant services, including government and nongovernmental resources. Determine which resources have stable, long-term funding, and which may be more precarious (this activity could be conducted with other stakeholders). Remember that traditional and informal community structures play a tremendously important role in supporting children, adolescents and their families; too often these groups are excluded from formal systems. If you are unsure where services are offered, this is an opportunity to find out.

Step 2: Hold consultations with children and adolescents

Hold consultations with children and adolescents themselves to learn about their priorities, needs and gaps. These consultations can give programs insight into how to better serve these groups while fostering informal “word of mouth” news about upcoming available services. Like community mapping, consultations offer important opportunities to solicit community input; identify social, economic and physical barriers to services and ways to mitigate against them; and identify opportunities for accessing services. Equally important, consultations create opportunities to learn more about how to support and serve the most vulnerable, such as children and adolescents living with disabilities or HIV.

Step 3: Invite/engage community advocates

Invite/engage community advocates conducting prevention/awareness activities or campaigns to regular meetings to discuss ways to better coordinate, e.g., identify opportunities for advocates to include information about available services in their campaigns, invite advocates to leave literature regarding violence-prevention/awareness-raising literature in the waiting room at your center; hold monthly meetings with advocates regarding pressing community issues, etc. *This engagement should include both formal leadership (i.e., community protection committees) and informal structures (i.e., traditional leaders, those involved in informal justice systems) that engage with children and adolescents.*

Step 4: Incorporate combined training

Incorporate combined training of individuals working within the system, including health care personnel, formal and informal community groups, service site workers, police and criminal justice system/legal teams. This will help foster a culture of working together by helping to build trust and understanding, and will, in turn, broadly increase capacity in caring for and managing victims/survivors. Mixed training can also help different cadres understand how other sectors function and will encourage dialogue and networking to improve standards of care for children and adolescents.

Step 5: Conduct specific outreach

Conduct specific outreach with persons who regularly interact with children/adolescents (teachers, pastors, community leaders, sports coaches, etc.), and invite them to visit the center/facility. Ensure that these individuals know how to handle cases of suspected child/adolescent sexual violence, are familiar with the services offered at your center and are aware of opportunities to refer children/adolescents. *This engagement should include both formal and informal leadership/structures that might engage with children and adolescents.*

of key actors using the diagram from the Companion Guide to identify current actors who were actively part of the referral system; available actors who are relevant and present, but do not play a part in the referral system; and actors who should be linked to the referral system, but do not operate within the county. In addition, the roles of the various actors identified in the Companion Guide were compared to the roles that were played by available actors operating in the referral pathways in both counties. Any discrepancies in suggested roles versus actual roles were highlighted and discussed. Also discussed were if, how and to what extent these discrepancies should be addressed if referral pathways are to be consolidated in the model counties.

In **Uganda**, to support the MGLSD and development partners in addressing the challenges regarding referrals and coordination among stakeholders, 4Children used the Companion Guide to facilitate and inform two multisectoral meetings in Central Uganda to identify and document lessons learned, promising practices and innovative approaches to strengthening referrals and coordination of sexual violence cases to ensure that children receive the necessary services and access justice. Government and nongovernment stakeholders representing health, education, social welfare, police, child protection and justice from Masaka, Lwengo, Rakai and Sembabule districts were brought together in a series of meetings to identify cost-effective and time-bound solutions in addressing bottlenecks in the referral pathways; also shared were experiences and lessons in applying these solutions. The two meetings were conducted approximately six weeks apart to allow for time to implement and reflect on the agreed recommendations from the first workshop, and to use the findings from this experience to generate practical tools across all sectors.

In Uganda, stakeholders at national level had already identified the key challenges to the referral system faced by children and those who are supporting children at risk of and experiencing sexual violence. However, although challenges were noted, specific bottlenecks were not addressed.

The first meeting facilitated by 4Children in Central Uganda used the Companion Guide to generate common understanding of what a referral pathway could look like and what its overarching purpose is. The Companion Guide section on referral pathways suggests a generic pathway (see Figure 2) that can be adapted to programs and contexts. The Companion Guide also highlights the importance of working with a range of actors to reaffirm that a multisectoral response requires a multidisciplinary team that includes

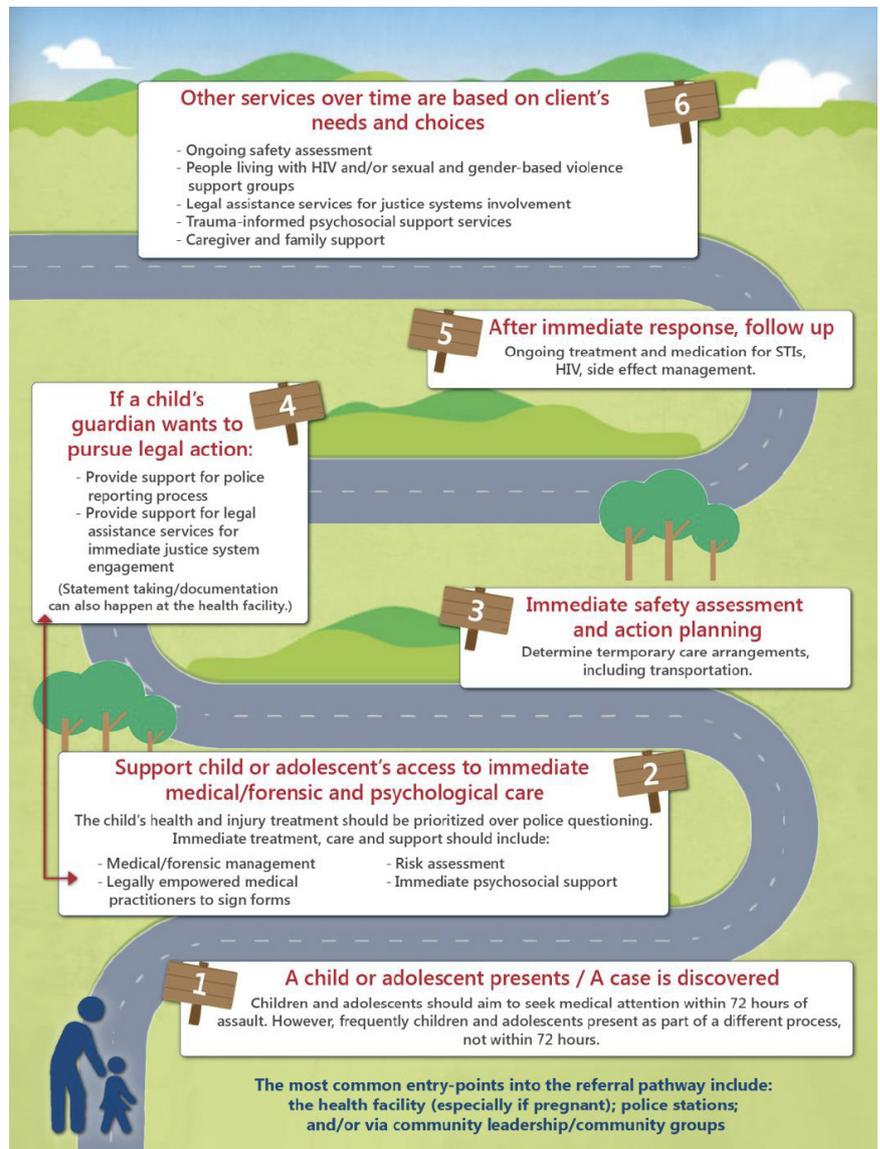


Figure 2. Illustrative referral pathway, Companion Guide, p. 7. referral

professionals from the medical, social, psychological, criminal, legal and educational fields. In addition, the Companion Guide's checklist on strengthening referral pathways was used as the basis of discussions to determine how the referral pathway in the participating districts could be strengthened. These provided opportunities for reflection regarding which actors are actively engaged in the referral pathway and the extent to which — and how — they work together to make an impact on the referral process. This reflection allowed for analytical and frank discussions between sectors to identify what works, what does not work, and why or why not in the current referral pathways within the model districts.

Key Outcomes of the Piloting Process

Conducting the pilots in both countries yielded a number of key lessons regarding both implementation and participation.

A generic referral pathway and simple recommended steps to develop a referral pathway allowed different actors to share their experiences openly. As noted above, Kenya

has established clear guidelines for clinical management of SGBV, including for children, and Uganda has a clear commitment to multisectoral responses. While these guidelines highlight the importance of multisectoral coordination and referral pathways in ensuring a comprehensive response to SGBV, they do not offer guidance as to how this can be done. The Companion Guide section on referral pathways suggests a generic pathway that can be adapted to programs and contexts.

Figure 3 (right) and the Companion Guide’s checklist on strengthening referral pathways (see Checklist, page 5) were used as the basis of discussion in both Kenya and Uganda regarding how referral pathways could be strengthened. Such discussion provided opportunities for reflection regarding which actors are actively engaged in the referral pathway and the extent to which — and how — they work together to impact on the referral process. This reflection allowed for analytical and frank discussions between sectors to review current referral pathways within the model countries and identify what works, what does not work, and why or why not.



Figure 3. Proposed duty bearers in the referral system identified in the Companion Guide.

Recognizing strengths as well as bottlenecks facilitated open discussion about how to improve referral pathways. Table 1, following page, below summarizes the strengths and bottlenecks in the referral systems that were identified in Kenya and Uganda. The practical approach stimulated practical ideas for how to resolve the challenges.

It was recognized that the combination of the above bottlenecks resulted in weak coordination that negatively impacts the effectiveness and overall functioning of the referral pathway. Seeing that the Companion Guide was used to identify bottlenecks, it was also applied to inform discussions regarding how these bottlenecks could be overcome. In this regard, draft *common messages* were developed to generate awareness on the value of a referral pathway, and to encourage their dissemination and uptake among service providers, community members and families. The messages were generated from workshop discussions and informed by a review of the VACS data that had been presented at the start of workshops.

As a result of the joint recognition that “it is everyone’s responsibility” to ensure child and adolescent survivors’ access to and progression along the referral pathway, job aids were developed in Uganda and discussed and refined with other sectors so that each sector is guided to play a more strategic and [cost] effective role in the referral pathway. The job aids seek to address the bottlenecks identified above (see Annex 1 for job aids). In addition, in Kenya, visuals were created to increase understanding in a user-friendly and accessible manner among community members, that SGBV is a criminal offense and should be reported to police if witnessed (see Annex 2 for visuals).

In addition to the job aids and visuals, longer term proposals were also made regarding how referral systems could be strengthened.

Kenya

- Harmonize and mainstream referral forms.
- Agree on entry points and generate understanding as to when these entry points should be accessed.
- Regularly share data on SGBV cases in Area Advisory Council (AAC) meetings to generate discussion on the functioning and effectiveness of the referral pathway, as well as the nature and quality of services provided within the framework of the referral pathway.

Uganda

- Even as efforts to prevent violence against children are strengthened, the health, justice and social welfare sectors must also ensure that quality response services are available to those children who do experience violence. Specifically, the police need to sensitize health officials, community development officers, probation officers and social welfare officers on the appropriate information and documentation needed to identify the case as one of sexual violence against children, so that they can investigate the case accordingly as such, and refer it to the courts.
- Strengthening response mechanisms is not enough; the role of the referral system to prevent violence must be emphasized as well. An effective early identification

Table 1. Strengths and bottlenecks in the referral pathway

| KENYA | UGANDA |
|--|---|
| Strengths in the referral pathway | |
| <ul style="list-style-type: none"> • Various actors do have examples of an improved response to SV cases. • DCS and civil society jointly agreed on the importance of harmonizing referral tools for smooth referrals and follow up of cases. • There are some existing effective approaches that give room for multidisciplinary engagements around complex SV cases within the pathway, notably a case conferencing methodology in use in Turkana County. | <ul style="list-style-type: none"> • There are functioning, albeit informal, referral pathways. These work primarily due to strong interpersonal relationships between actors across sectors and within sectors. • Even though the referral pathway is informal, the services a child receives are documented, even if the referral is not. • There is strong commitment to upholding the best interest of the child, and to ensuring a “victim first” response. |
| Bottlenecks in the referral pathway | |
| <ul style="list-style-type: none"> • Different agencies use different referral pathways that are customized to the needs of the individual organization or project. • Different entry points are used to report incidences of SGBV. • Tools and reports are not harmonized or coordinated between sectors and actors. In particular, tools developed and applied by non-state actors lack legal recognition and, accordingly, are often not considered in judicial processes. • Guidelines and principles around standards of care for children affected by SGBV are not effectively being upheld, as sectors either had their own standards of care (as is the case for health), or standards were informed by programmatic standards. • Limited staff capacity to provide age-appropriate services for children affected by SGBV and existing attitudes about children, gender and SGBV are key impediments for ensuring that cases are considered with urgency, referred, and receive follow-up. • Police and justice officers/officials are often not involved in discussions on referrals, and this was considered a key bottleneck to ensuring access to justice. • Low involvement of families and communities in encouraging reporting impacted on the ability of the child to access the referral pathway and receive the needed services, including justice. • There is a lack of emphasis on integration of household economic strengthening initiatives and ongoing psychosocial support as essential components of the referral. • Limited understanding of the importance of collecting essential information, how this data should be collected, and by whom, impede on and challenge prosecution processes. | <ul style="list-style-type: none"> • There is a generally poor understanding of the importance of urgent bidirectional referrals, specifically between police and health, and the importance of determining whether a case is one of sexual violence (and, hence, a criminal case). • There are different understandings regarding what the entry point into the referral system should be. • Police representatives highlighted that referral forms from both health workers and social workers do not provide correct and/or sufficient information to determine whether a case is one of sexual violence. • Religious leaders and teachers are often not involved in conversations around reporting; this was considered to be an impediment. • Financial costs related to reporting and referrals are a key impediment. • Psychosocial support was noted as a key service, however participants noted there was little guidance as to what exactly it entails, and who should provide it. |

Table 2. Common and joint messages

| MESSAGES ON PREVENTION AND REPORTING |
|--|
| <p>Messages for general public, including families</p> <ul style="list-style-type: none"> • Stop violence before it occurs. Once a child experiences abuse, he/she is likely to suffer repeated instances throughout childhood. Prevent the abuse of children in your area by sharing this message with someone today. • Children who experience physical violence often report that an adult family member has perpetrated it. What have you done this week to report such cases and to ensure the children in your area receive the necessary services?_ • The primary purpose of reporting is to protect the child. Reporting may also result in protecting other children in the home or in the community. Please report any suspicion of abuse immediately. • Children may be abused in a family, within an institutional or community setting by those known to them or, more rarely, a stranger. Please report any suspicion of abuse immediately. • SGBV against children is a criminal offence. Encourage, support and educate on the importance of reporting and giving witness account. Free call lines in Kenya through which to report are Children’s Helpline (116) and Gender Violence Helpline (116). • Myth: Strangers carry out child abuse. • Fact: Research indicates that 90% of abuse results from domestic causes and is committed by an individual known to the child. Please report any suspicion of abuse immediately. • Myth: Learning about child protection is harmful to your children. • Fact: Research indicates that appropriate education makes children more confident and able to react to dangerous situations. Report any suspicion of abuse immediately. <p>Messages for service providers</p> <ul style="list-style-type: none"> • What does a prevention response look like to you? Have you had conversations with your colleagues recently about prevention? • What does coordination look like to you? Have you had conversations with your colleagues recently about coordination? |

system should be strengthened in which vulnerable and at-risk children are linked into the case management system to ensure risks of harm or other vulnerabilities are minimized. In addition, the social welfare and health sectors should take the lead in providing more support to parents and caregivers/guardians through home visits and community parenting sessions.

The lessons and recommendations identified during the modeling of the Companion Guide in Kenya and Uganda have been generated as a result of the active participation of key sectors and actors throughout the process. While the modeling of the Companion Guide was facilitated by 4Children, ensuring the involvement of statutory and non-statutory bodies allows for the recommendations to be taken forward in a manner that is not dependent on 4Children’s technical or financial support.

Reflections on Use of the Companion Guide

It is commonly accepted that multisectoral coordination is important and that in practice it remains hard for referral networks to function. Bringing people together to share experiences can be difficult – individuals from different sectors or government versus civil society can find it hard to talk about their own challenges. The Companion Guide provided simple generic tools that facilitated common

discussion on what a referral process *should* look like and identified what the local bottlenecks might be.

Some of the most important challenges that the process identified were the practical barriers that arose when different actors failed to receive the correct documentation or when the referral was not made in the correct way. In Uganda, one of the most important aspects of the process was having different actors explain to their colleagues *why* it is so important to receive the correct documents. This process of realization can only happen in practice at a local level.

In both countries, there are new case management tools. Having a specific focus on an issue that all actors see as really important—addressing the needs of child and adolescent survivors of sexual violence—made it possible to look at broader referral processes while also allowing people to focus on concrete and specific issues.

Annex 1: Job Aids Developed in Uganda

JOB AID 1: KEY STAKEHOLDER ROLES DEVELOPED BY WHOLE GROUP, MASAKA DISTRICT



JOB AID 2: COMMUNITY DEVELOPMENT OFFICERS

Basic information needed from client

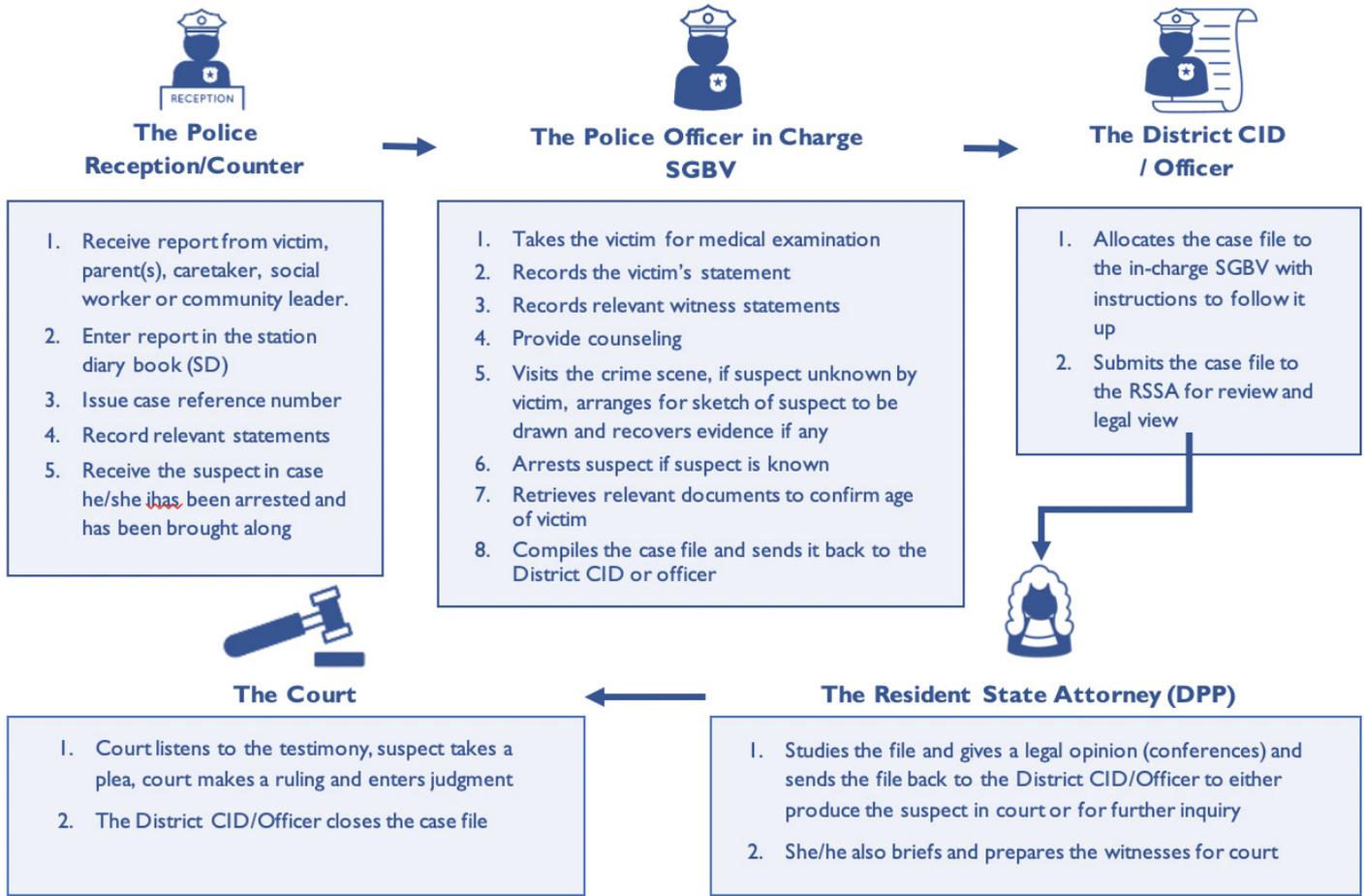
1. Client's biodata: name, sex, age and class (if in school)
2. Name of caregiver/parents
3. Place of residence and contact details
4. Date of reception
5. Type of case
6. Date of case occurrence
7. Statement from client/caregiver
8. Relationship with the caregiver
9. Name and age of the offender and their address/location
10. Relationship of offender with the victim
11. Feedback provision
12. Action taken after sexual abuse before coming to the CDO
13. Action taken by the CDO and or services needed at referral e.g. Counseling, Medical etc.



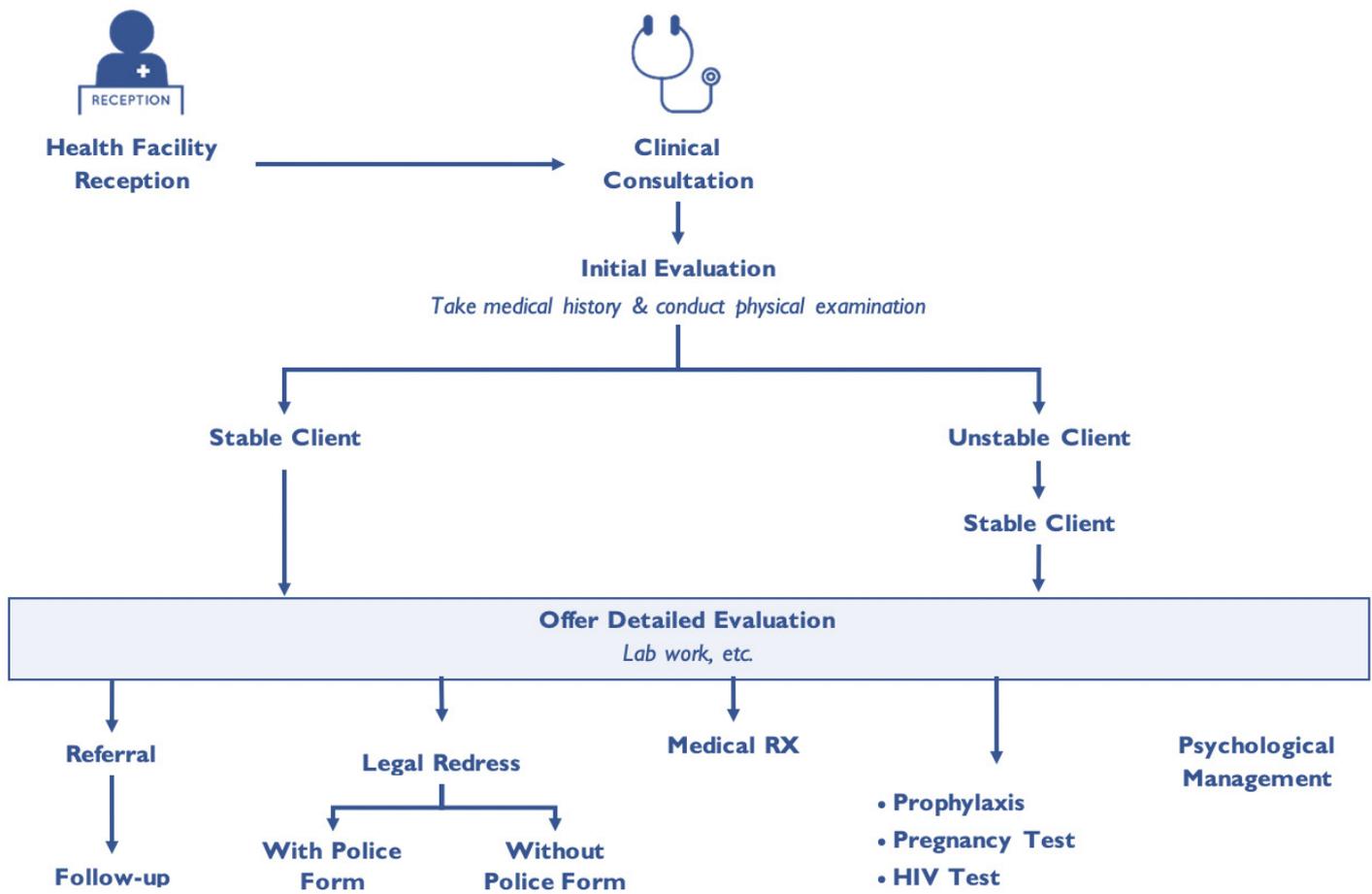
Relevant supporting documents required

1. Birth certificate, Baptism card, Immunization card
2. Police Reference Case Number
3. Contact details for the key stake holders
4. Referral Form
5. Letter from Local Council 1 Chairman (LC1)
6. Consent letter

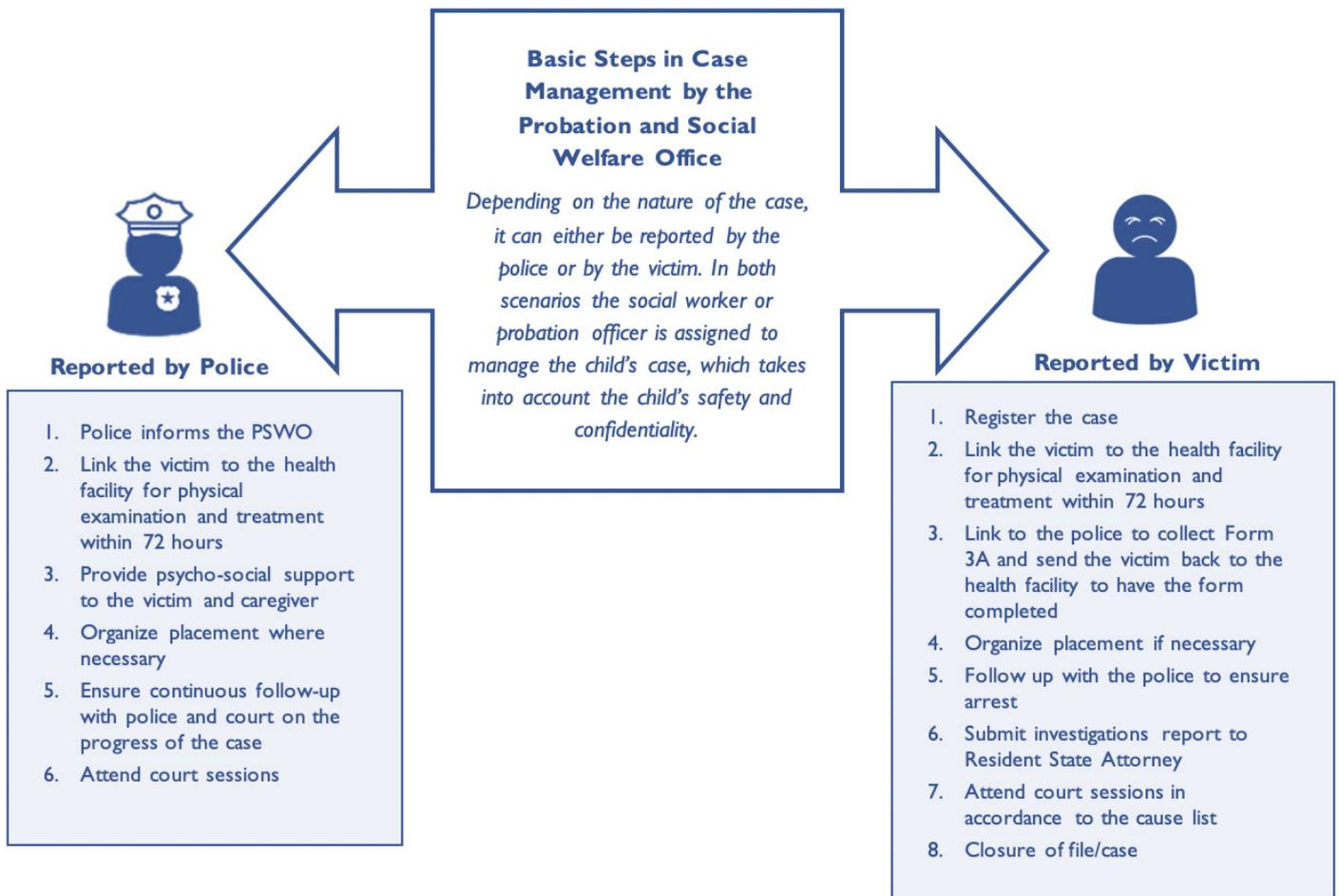
JOB AID 3: POLICE SECTOR FLOW CHART



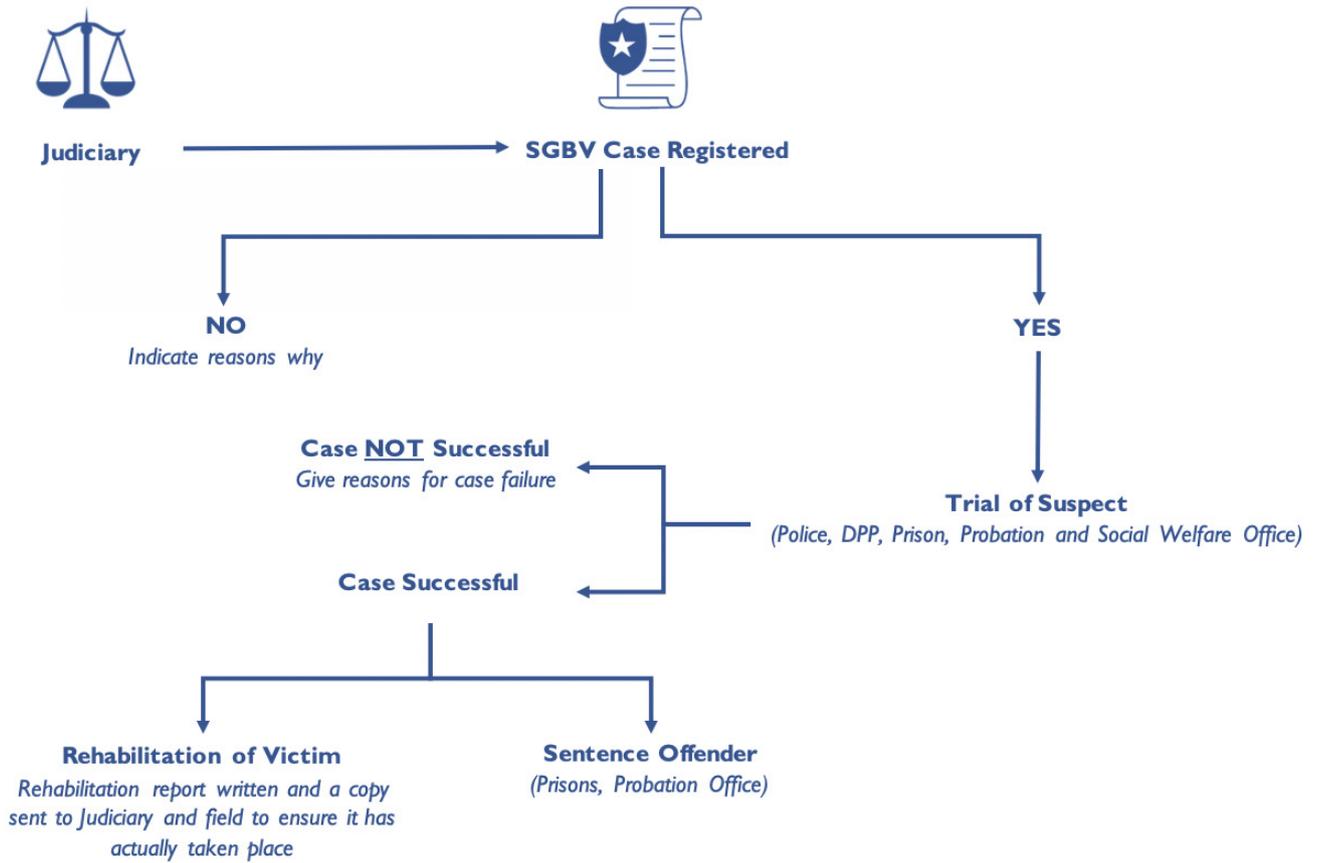
JOB AID 4: HEALTH SECTOR FLOW CHART



JOB AID 5: PROBATION AND SOCIAL WELFARE SECTOR FLOW CHART



JOB AID 6: JUDICIARY SECTOR FLOW CHART



Annex 2: Visuals Developed in Kenya

DURING PROJECT CONSULTATIONS FOR USE IN LOCAL SENSITIZATION ON SGBV

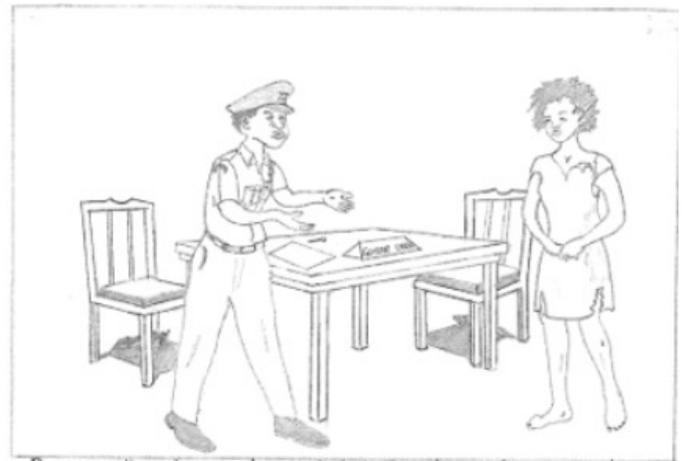
SGBV AGAINST CHILDREN IS
A CRIMINAL OFFENCE, ENCOURAGE,
SUPPORT AND EDUCATE ON THE IMPORTANCE
OF REPORTING AND GIVING WITNESS ACCOUNT.
FREE CALL LINES:
CHILDREN HELPLINE : 116
GENDER VIOLENCE HELPLINE : 1195



Don't blame yourself, talk to someone about the abuse/act.
Take action immediately.



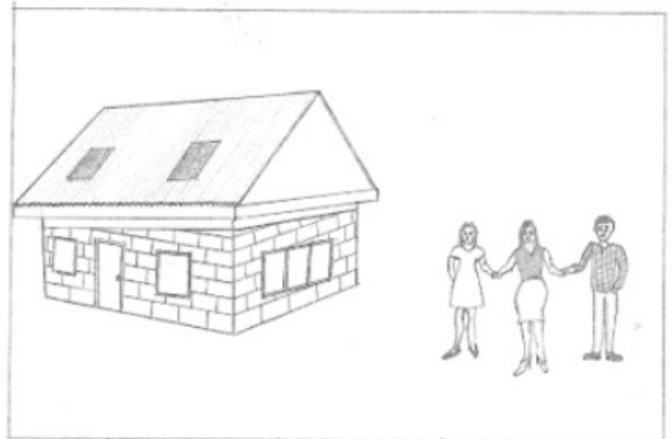
Get medical attention immediately or within 24 to 72 hours (3 days)



Preserve all evidence and present it to the police station or the health facility.



Court should hear SGBV cases fast to avoid prejudice/interference.



After trial the guilty party/culprit should serve a jail sentence and the victim is free to link and socialize with friends and family.



Coordinating Comprehensive Care for Children (4Children) is a five-year (2014-2019), USAID-funded project to improve health and well-being outcomes for Orphans and Vulnerable Children (OVC) affected by HIV and AIDS and other adversities. The project aims to assist OVC by building technical and organizational capacity, strengthening essential components of the social service system, and improving linkages with health and other sectors. The project is implemented through a consortium led by Catholic Relief Services (CRS) with partners IntraHealth International, Pact, Plan International USA, Maestral International, and Westat.

