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BUILDING CAPACITY ON POST-RAPE CARE FOR CHILDREN AND ADOLESCENTS TECHNICAL WORKSHOP

DAR ES SALAAM, TANZANIA

SEPTEMBER 4–5, 2013

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

FEBRUARY 2014

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CONTENTS

- ACRONYMS..... v**
- INTRODUCTION..... 1**
- BACKGROUND..... 5**
- PRESENTATIONS..... 7**
- SMALL GROUP DISCUSSIONS..... 15**
- APPENDIX A. COMMUNITY ACTION PLANS..... 25**
 - ACTION PLAN FOR PRC—HEALTH SECTOR.....27
 - ACTION PLAN FOR PRC—COMMUNITY.....29
 - ACTION PLAN FOR PRC—JUSTICE SECTOR.....31
 - ACTION PLAN FOR PRC—SOCIAL WORK AND EDUCATION.....35
- APPENDIX B. MEETING AGENDA..... 41**

ACRONYMS

AIDS	acquired immunodeficiency syndrome
BCC	behavior change communication
CBET	competency-based education and training
CSA	child sexual abuse
EC	emergency contraception
FBO	faith-based organization
GBV	gender-based violence
GCD	Gender and Children Desk (in police stations)
HCW	health care worker
HIV	human immunodeficiency virus
HTC	HIV testing and counseling
LGAs	Local Government Authorities
LVCT	Liverpool VCT
M&E	monitoring and evaluation
MOHSW	Ministry of Health and Social Work
MUHAS	Muhimbili University of Health and Allied Sciences
NGO	nongovernmental organization
OSCE	objective structured clinical examination
PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PPE	Personal Protective Equipment
PRC	post-rape care
PSS	psychosocial support
REPSSI	Regional Psychosocial Support Initiative
SGBV	sexual and gender-based violence
SOP	standard operating procedure
STI	sexually transmitted infection
TOT	training of trainers
USAID	U.S. Agency for International Development
VAC	violence against children

INTRODUCTION

In recent years, the Tanzanian Ministry of Health and Social Work (MOHSW) has spearheaded efforts to develop regulations, guidelines, and training packages for post-rape care (PRC) for children and adolescents. Building on these initiatives, on September 4–5, 2013, 52 representatives and experts from the MOHSW and other ministries, the U.S. Agency for International Development (USAID), national and international nongovernmental organizations (NGOs), the United Nations Children’s Fund, the Muhimbili University of Health and Allied Sciences (MUHAS), the International Association of Forensic Nurses (based in the United States), and Liverpool VCT (LVCT) (based in Kenya) came together for the Building Capacity on Post-rape Care for Children and Adolescents Technical Workshop to discuss and recommend actions that will lead to the development of PRC guidance specifically for children and adolescents in Tanzania. The workshop provided an opportunity to begin the process of developing national standards and coordinated protocols for care for children and adolescents who have experienced sexual violence and exploitation. The primary resource document used by participants at the workshop was *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs* (See Box 1).

WORKSHOP OBJECTIVES

The objective of the Building Capacity on Post-rape Care for Children and Adolescents Technical Workshop was to build country capacity to move forward a PRC for children and adolescents agenda in Tanzania. Specifically, the subobjectives of the technical workshop were to:

1. Provide an overview of *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs* document.
2. Present country-level experiences and challenges of providing clinical care for children and adolescents who have experienced sexual violence.
3. Identify elements from the Technical Considerations and develop preliminary plans on developing PRC guidelines and protocols in Tanzania.
4. Strategize to identify technical assistance needs and sources to support development of Tanzanian PRC technical guidelines.

The workshop had three main components (see Appendix B: Workshop Agenda for specific details).

A series of country-level presentations identified different components of PRC and the challenges in providing PRC services to children and adolescents. The presentations came from the perspective of workshop participants, including policymakers, programmers, and PRC providers to children and adolescents. They covered policies related to child protection and gender-based violence (GBV); the clinical and medical forensic management strategies used to implement PRC; research on child sexual abuse (CSA); an overview of curricula and training programs offered to PRC service providers; and an analysis of social services and psychosocial support (PSS) for children and adolescents (and their families) who have experienced sexual violence.

On the first day of the workshop, four small groups discussed core components of comprehensive responses to sexual violence and exploitation (provided in Table 1, pages 5 and 6 of *Technical Considerations*). Each group was assigned one of the following sectors: health care, police and judicial system, social services and education, and community. Each of the four small groups identified barriers to applying the responses and suggested ways to overcome them.

On the second day of the workshop, four small groups developed actions plans and recommendations for the way forward on PRC for children and adolescents. Each group was assigned one of the following sectors: health care, police and judicial system, social services and education, and community. Each group developed action plans and made recommendations focusing on the development of PRC guidelines for children and adolescents; capacity building for service providers; referrals and linkages across sectors and between ministries and civil society; policies and laws; commodities and supplies for PRC; and the monitoring and evaluation (M&E) of PRC activities and programs. Each group presented and discussed its key recommendations in a plenary session.

Participants completed a brief evaluation at the end of the second day. Most reported that the four meeting sub-objectives were met. Participants particularly appreciated the opportunity to examine the *Technical Considerations* and question the authors on the role of forensic nurses in the United States. They reported that the meeting successfully provided a forum to share promising practices from Tanzania, Kenya, and the United States that address challenges in designing, implementing, monitoring, and evaluating integrated services for the target populations. Participants also mentioned enjoying the small group discussions and the opportunity to informally share experiences with colleagues who are working in the same field.

Recommendations and comments from participants at the workshop included:

- *It was a good start to beginning the process of developing separate guidelines on PRC for children and adolescents in Tanzania.*
- *It was good to be with colleagues and see that the issue of GBV and violence against children (VAC) is finally being discussed seriously.*
- *This workshop helped give us ideas to consolidate our plans and develop one unified strategy.*

BOX I. THE CLINICAL MANAGEMENT OF CHILDREN AND ADOLESCENTS WHO HAVE EXPERIENCED SEXUAL VIOLENCE: TECHNICAL CONSIDERATIONS FOR PEPFAR PROGRAMS

The *Technical Considerations* aim to serve as a guide for primary health providers on appropriate care of children and adolescents who have experienced sexual violence and exploitation based on current evidence-based practices. They are expected to inform the efforts of PEPFAR implementers and others engaged in the clinical care of children as well as in HIV and AIDS prevention, care, and treatment to strengthen community-based responses to children who have experienced sexual violence and exploitation. They should be implemented in line with national guidelines in the provider's country of practice. The focus is specifically on the clinical management of children who experience sexual violence and exploitation, but a holistic response is needed. Communities should also strive to develop comprehensive systems to respond to the needs and rights of these children. The comprehensive response includes government (e.g., clinics, law enforcement and judiciary, policymakers, social welfare/child protective services, and counselors), and nongovernmental and civil society organizations.

- *Working together was good. We should continue to include all stakeholders in next steps.*
- *This workshop showed the way for modifying existing structures for better PRC for children in Tanzania.*
- *There should be more efforts on prevention activities.*
- *From the experience shared and the planning together, we need to speed up this process since there is a lot to be done. Advocacy for giving priority in resource allocation is the key.*
- *I have learned that it is important to review what is already being done to avoid duplication of activities before making final recommendations.*
- *More effort should be geared at strengthening multi-sectoral collaboration.*

BACKGROUND

A 2011 survey on VAC conducted in Tanzania states that nearly 3 out of every 10 females aged 13 to 24 in Tanzania reported experiencing at least one incident of sexual violence before turning age 18. Among males in the same age group, 13.4 percent reported experiencing at least one incident of sexual violence prior to the age of 18. Half of females and two out of every three males did not tell anyone about their abuse. One in five females and one in ten males who experienced sexual violence prior to age 18 sought services; one out of eight females and fewer than one out of twenty males actually received services.¹ To address VAC and GBV, a government multisector task force agreed to key “priority responses” across a number of sectors that include the police and justice, education, health and social welfare, local government, community development, faith-based organizations (FBOs), and civil society.

However, significant challenges remain. The Law of the Child Act was passed in 2009 without funding and little infrastructure in place to support the changes that were outlined in the law. Other challenges include poor linkages among prevention and response actors; difficulties in coordinating PRC interventions across many regions and urban and rural populations; and a lack of specialized pediatric PRC services in the health, social services and education, and the police and judicial system sectors. The stigma attached to sexual violence has resulted in a culture of silence around this issue and reluctance on the part of the community to seek the PRC services offered by the government and other service providers in civil society. The dearth of resources in all sectors means that the scaling-up of PRC services advances at a slow pace.

Though mindful of the constraints, the workshop participants seized the opportunity to network across sectors and discuss the practical ways in which Tanzania can move forward on addressing PRC for children and adolescents. *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs* provide a clear model of the guidelines that Tanzania could develop in a relatively short timeframe and use as the basis of PRC training programs and a standardized approach to PRC for children and adolescents in all sectors. The workshop participants’ goal is to strive for a comprehensive response to sexual violence, including comprehensive medical management by health care providers, short- and long-term PSS, social welfare/child protective services, and legal assistance to help the children and adolescents who have experienced violence and exploitation access healing and justice.

¹ See the presentation *Post Rape Care for Children: Tanzania’s Experience* by Dr. Grace Mallya, M.Med (PHC) Coordinator: Gender and Reproductive Health MOHSW Tanzania on page 10.

PRESENTATIONS

During the meeting, presenters shared country-level experiences and challenges of providing clinical care for children and adolescents who have experienced sexual violence and exploitation.

POST-RAPE CARE FOR CHILDREN: TANZANIA’S EXPERIENCE

Dr. Grace Mallya, Coordinator: Gender and Reproductive Health, Ministry of Health and Social Work

This keynote presentation summarized the scope of VAC and the progress in government responses to VAC and GBV, the range of PRC services offered by the health sector, and the challenges in providing these services.

- Nearly 3 out of every 10 females aged 13 to 24 in Tanzania reported experiencing at least one incident of sexual violence before turning age 18. Among males in the same age group, 13.4 percent reported experiencing at least one incident of sexual violence prior to the age of 18. One-half of females and two out of every three males did not tell anyone about their abuse. One in five females and one in ten males who experienced sexual violence prior to age 18 sought services. One out of eight females and fewer than one out of twenty males actually received services.
- In 2011, a government task force agreed to “priority responses” that included developing regulations to implement the Law of the Child Act; policy guidelines and GBV/VAC medical management guidelines with training package; a strategy for child justice reform; guidelines and standard operating procedures (SOPs) for GCDs in police stations; a revised national Code of Conduct for teachers; a draft of child protection guidelines for schools; and guidelines for budgeting for child protection at the Local Government Authorities (LGA) level. The MOHSW has developed an algorithm for receiving PRC clients, a guide for communicating with children, and PRC protocols for nurses, police, technicians, and counselors. The MOHSW has worked to integrate objective structured clinical examination (OSCE) in health care facilities and to involve the LGA in PRC.
- The challenges included the need for stronger coordination, a lack of specialized pediatric PRC services, the scarcity of community response mechanisms, poor linkages among prevention and response actors, and a dearth of resources to scale up services.

ADDRESSING SEXUAL AND GENDER-BASED VIOLENCE/VIOLENCE AGAINST CHILDREN IN TANZANIA

Jayne Lyons, Pathfinder International

This presentation discussed the links between VAC and poor health outcomes, links between justice/human rights and public health, and clinical approach competencies.

- Pathfinder International’s mission is to ensure that people everywhere have the right and opportunity to live a healthy sexual and reproductive life.
- Children and adolescents who have experienced sexual and gender-based violence (SGBV/VAC) are at risk of contracting HIV through direct transmission during sexual assault, rape, or coerced unprotected sex.
- The Sexual Offences Provision Act of 1998, which was revised in 2000, calls for extreme punishments for sexual offenses and decriminalizes consensual sexual conduct between adult men, sex work, and personal use of narcotics. Children and adolescents who have experienced SGBV/VAC and those exposed to this violence are at higher risk of adopting other risky behaviors. This puts them at risk of being revictimized and having their behavior criminalized.
- Childhood experience of traumatic stress leads to poor developmental outcomes, including mental health disorders. The abusive cycle begets abuse and puts people at risk of engaging in illicit drug use, early initiation of sexual activity, and transactional or paid sex. Tanzanian law prohibits the use of children for sex work, but recent studies in Tanzania have found that it is common and rarely effectively prosecuted.
- Pathfinder promotes training models for health care providers who care for survivors of SGBV and VAC by linking human rights and the public health imperative to reduce violence as a matter of basic human dignity. Pathfinder supports an approach that links trained community health care providers to both the local government through the ward tribunal and health services through trained health providers who can ensure that survivors will not be arrested or prosecuted for seeking care.

USE OF THE OBJECTIVE STRUCTURED CLINICAL EXAMINATION AND MICROTEACHING METHODOLOGIES DURING PRE-TEST OF GENDER-BASED VIOLENCE/VIOLENCE AGAINST CHILDREN TRAINING MATERIALS

Dr. Samuel Likindikoki, Pathfinder International

- This presentation, accompanied by video clips, describes the training techniques of microteaching and Objective Structured Clinical Examination (OSCE). These techniques test acquisition of clinical skills even when difficult ethical issues limit “practice” with children.
- In microteaching, the supervisor and trainee review a 10-minute videotape of a practice session and conduct a “post-mortem.” Initially the supervisor demonstrates the skill to be practiced. Group members then select a topic, prepare, and practice a lesson. Supervisors use feedback sheets for evaluations. The evaluation covers preparation, personal attributes, lecture and facilitation, application of learning principles, and accurate presentation of the material.
- In the OSCE, a trainee circulates through a series of short stations. At each station, trainees are expected to perform specific clinical tasks. Real or simulated patients (actors or electronic dummies) are used. The OSCE allows trainees to practice obtaining information from a patient. This helps trainees establish rapport and communicate, solve problems, interpret data, and perform physical examinations.

THE ADVANTAGES OF A COMPETENCY-BASED EDUCATION AND TRAINING CURRICULUM

Dr. Rose Laisser, Pathfinder International

This presentation described the advantages of a competency-based curriculum for health care providers and the value of a training system that awards credits to successful students.

- Competency-based education and training (CBET) is organized around the functions of the intended learners and their setting. This allows the trainer to bring up difficult situations such as those that can be found in SGBV and VAC. For instance, a clinical assistant in a local health center is able to elicit information for a hidden rape scenario from an adolescent in history taking—and refer the case forward.
- Health care workers (HCWs) trained using the CBET curriculum serve communities and survivors of GBV and VAC by applying knowledge, skills, and wider attributes of poverty, human rights, and HIV concepts in managing GBV. The CBET curriculum favors CHWs working independently in unfamiliar and complex situations and solving open-ended problems with many variables.
- CBET curriculum consists of modules with credits; credits measure and express learning equivalence. They reward incremental progress of learners, facilitate knowledge transfer, recognize prior learning, and contribute to the definition of professional standards.

POLICIES, IMPLEMENTATION AND CHALLENGES TO PROVIDING POST-RAPE CARE

Dr. Witness Motta, Senior Technical Advisor, Engender Health/RESPOND

This presentation described the objectives of the National Policy Guidelines, guiding principles for PRC, post-rape services, challenges to implementing these services, and recommendations for the way forward.

- The specific objectives of the National Policy Guidelines inform development of GBV management guidelines and protocols for children and adolescents who have experienced GBV; guide the implementation of GBV prevention and response efforts; establish M&E systems for GBV interventions; and guide linkages among multi-sectoral stakeholders in GBV-related service provision.
- Guiding principles of PRC for children and adolescents include promoting the child's best interest, involving the child in decision making, and nurturing the child's resilience. Guiding principles for service providers include assessing the child in a child-friendly environment and ensuring that a parent/guardian is present at all times (while ensuring that the guardian/parent presents no threat to the child).
- Post-rape care services include clinical evaluation, clinical management, preventive treatments (HIV post-exposure prophylaxis [PEP] and emergency contraception [EC]), counseling services, and referral to legal and social services and follow-up.
- Funding at the national and local government levels is insufficient, and providing services becomes a challenge. For health care providers, the challenges include the lack of rape care kits

and inadequate supplies of HIV test kits, the lack of standard GBV referral forms, difficulties in gathering forensic evidence, and weak links between clinical and community providers. Distance to the health facilities also means that some survivors report to the facility very late hence services like PEP and EC become less timely and effective.

- For survivors, the challenges include a reluctance to seek health services because of the stigma or because the perpetrator is a family member. Expenses may also be a deterrent when survivors cannot cover the cost for things such as GBV forms, legal aid, protection, and psychosocial counseling.
- Recommendations include advocating for inclusion of GBV activities into the comprehensive council health plans, strengthening integration of GBV into other existing services, providing free GBV services, joint planning between prevention and clinical partners, and filling gaps in supplies of rape kits and HIV test kits.

CLINICAL MANAGEMENT OF CHILD SEXUAL ABUSE AND RAPE: EXPERIENCE FROM A STUDY IN MOROGORO

Dr. Felix Kisanga, Lecturer, Muhimbili University of Health and Allied Sciences
Dr. Projectine Muganyizi, Lecturer, Muhimbili University of Health and Allied Sciences

In this session, two lecturers from MUHAS shared information on CSA studies conducted in Tanzania, described a study under way in Morogoro, identified the challenges in dealing with CSA, and recommended a multi-sectoral approach.

- A school-based survey conducted in Temeke District in 2010 among 1,359 students found CSA prevalence of 26 percent among girls and 30 percent among boys. The risk for any abuse and forced sex increased with age. Negative health consequences were more prevalent among those abused, those exposed to forced penetrative sex, and girls.
- A study that began in 2012 is under way to assess the effectiveness of an interventional package on rape management in Morogoro. The intervention includes training of health care providers on the management of rape cases using guidelines from the World Health Organization and the United Nations High Commission for Refugees; introducing rape kits to eligible health centers; providing community education on PRC; and documenting cases and studying health facilities and cases reported to police. Baseline data were gathered on people's and HCWs' Knowledge Attitudes and Practices and perceptions in health facilities and police six months before intervention. Researchers visit participants in the study every month and meet with community leaders every three months to discuss the progress of the study. Continual supplies of forensic rape kits, PEP, and EC pills are assured during the intervention. The study will end in June 2014. To date, successes include increased report of rape to community leaders; police and health centers in the intervention area; a readiness of village leaders, HCWs, and police to cooperate and act to end violence; and compliance on PEP and EC.
- Recent studies in Tanzania show that disclosure of sexual violence is hampered by fear of negative social responses and the stigma associated with child exploitation and violence. The few children and adolescents who had experienced sexual violence and exploitation who reported incidents to the criminal justice system describe being discouraged by the manner in which their

issues were handled at all levels of the response, including the community and the criminal justice and health care systems.

- Care for survivors requires a multi-sectoral approach from care providers in the following domains: health, legal/justice, psychosocial, and safety/security. Essential post-rape medical care includes documentation of injuries, collection of forensic specimen, treatment of injuries, prevention for sexually transmitted infections (STIs)/HIV and pregnancy, and provision of PSS.

THE KENYA EXPERIENCE: PROVIDING POST-RAPE CARE FOR CHILDREN AND ADOLESCENTS

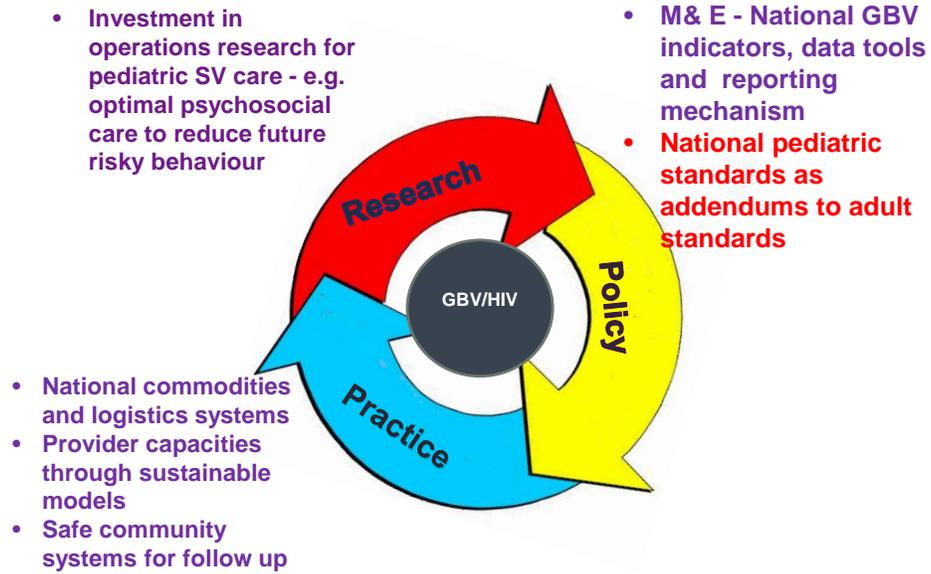
Dr. Lina Digolo, Care and Treatment Manager, Liverpool VCT Care and Treatment

This session presented the model an indigenous Kenyan NGO providing comprehensive SGBV services uses, as well as the lessons the NGO learned from its work.

- A 2010 VAC household survey in Kenya showed that 31.9 percent of females and 17.5 percent of males interviewed had experienced sexual violence prior to the age of 18. Additionally, 27 percent of females and 33 percent of males had experienced emotional violence before age 18. Among female and male survivors of sexual and emotional violence, only 13.9 percent and 3.3 percent respectively, sought and received services.
- Kenya has recognized sexual violence as a serious human rights issue and public health problem. It has developed legislation, policies, service guidelines, and training curriculum to support the management of survivors of sexual violence. In addition, Kenya has enhanced multi-sectoral coordination. Efforts include having one body, the National Gender and Equality Commission, mandated to coordinate all sectors dealing with management of survivors of violence, development of cross-sectoral SOPs and data collection tools, and scale-up of PRC service provision centers in several counties across the country.
- Kenya has experienced challenges similar to other African countries in the management of pediatric survivors of violence. (This population forms approximately 54 percent of total survivors.) Some of the gaps in PRC for children and adolescents include insufficient provider capacity in management of pediatric patients; rudimentary legal and psychosocial training of HCWs; a dearth of pediatrics information in training curricula and national guidelines; a lack of SOPs, protocols, and long-term PSS; and inconsistent availability of health commodities. The challenges of engaging with the community include a lack of awareness, the stigma of sexual violence and a culture of silence, out-of-court settlements, and a lack of safe homes for children and adolescents who have experienced sexual violence and exploitation.
- LVCT's PRC/GBV program is built on the LVCT Hatua model, a dynamic research policy practice model that focuses on research questions and methodologies that respond to policy and practice gaps. Some key considerations highlighted for setting up and the scaling up of successful PRC services include early and continuous stakeholder consultations; well-defined standards of care for service delivery and evidence collection and management (SOPs, protocols, and national guidelines); and standards for capacity building of targeted service providers.

- The slide below illustrates LVCT's recommendation for improvement of services for pediatric survivors of violence.

Recommendations.. Research, Policy, Practice



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PRACTITIONER'S PERSPECTIVE: ADDRESSING THE NEEDS OF CHILDREN AND ADOLESCENTS WHO HAVE EXPERIENCED SEXUAL VIOLENCE

**Dr. Margareth Mukuchilo, Mbagala Rangitatu Hospital
Francisca Makoye, Social Work Officer, Ilala Municipal**

In this session, a medical doctor and a social worker presented three cases of PRC, described the services offered to the survivors and their families, and identified the challenges of providing PRC.

- VAC services provided by Social Welfare are described in the Law of the Child Act of 2009 session 94 subsection 1–7, which stipulates that the local government authority shall have a duty to safeguard and promote the welfare of the child within its area of jurisdiction.
- Case 1: A female child aged three years and eight months was brought by her parents to the hospital six hours after she told them their neighbor penetrated his “thing” into her vaginal orifice. The suspect was identified and arrested. The child had not taken a bath or changed clothes. Parental consent for an examination was obtained. The child’s mental state was judged to be alert but fearful and anxious. A head-to-toe examination showed stable vital signs and no other physical injuries. Genital and anal examination revealed a stained inner garment and laceration on the labia minora and hymen.
- Case 2: A twelve-year-old primary schoolgirl was brought by her mother to the hospital with the complaint of having been raped by an unknown man on the way to school early in the morning eight hours earlier. The girl had changed clothes and taken a bath before coming to the hospital. The child’s mental state was fearful and anxious. A genital and anal exam revealed tears in the vaginal orifice.
- Case 3: A 16-year-old girl was raped by a stranger when looking for work as a house girl. This man persuaded her to go to his house where he raped and sodomized for three days. She was saved by community members. The issue was reported to police, and the man was arrested. In collaboration with police and community members, the girl was sent to the hospital for treatment. Three months after her ordeal, she was diagnosed HIV positive and is pregnant.
- Currently, she lives in a temporary shelter under the custody of a social welfare officer while the case proceeds at District Court. Investigations in all three cases included Hb level, hepatitis B Serum antigen, and an HIV test. The survivors received PEP and presumptive treatment for STI. The survivors and their families also received counseling.
- The three cases reveal the following challenges in dealing with VAC: the lack of rape kits; few staff trained in comprehensive management; the cost of drugs; few police trained and equipped for the handling of forensic evidence; stigma at the community level, which discouraged survivors from seeking follow-up care; the lack of awareness of available PRC services; a limited amount of temporary shelters; and no network to deal with VAC issues.

PSYCHOSOCIAL SUPPORT IN PRC FOR CHILDREN AND ADOLESCENTS

Davina James Kabalo, Regional Training Officer, Regional Psychosocial Support Initiative

This session defined the term “psychosocial” as the dynamic relationship between the intrapersonal and the interpersonal, described the three domains of PSS, and listed the PSS programs the Regional Psychosocial Support Initiative (REPSSI) offers.

- Sexual abuse challenges the resilience, development, and psychological wellbeing of children. It may also cause behavioral and emotional problems. PSS covers three domains: emotional and spiritual wellbeing (intrapersonal), such as the ability to know and manage one’s emotions; social wellbeing (interpersonal), such as the ability to get along with others; and skills and knowledge (cognitive), such as competencies to cope with stress. Under the REPSSI model, PSS is key for the healing of children and adolescents who have experienced sexual violence and abuse and their families, and communities REPSSI provides PSS programs; a community-based certificate in working with children; and a teacher’s diploma in psychosocial care, support, and protection accredited by the University of KwaZulu Natal.

SMALL GROUP DISCUSSIONS

On the afternoon of the first day, participants divided into small groups in the following categories: the health care sector, the police and judicial system sector, the social services and education sector, and the community sector. Groups considered the obstacles to using the core components of a comprehensive response to sexual violence and exploitation that meet the range of medical, legal, and psychosocial needs of the child. They also suggested ways of overcoming these obstacles.

This section summarizes the small groups' discussions in which participants identified the constraints and lack of resources that impede the coordinated delivery of quality PRC services by trained and fully equipped personnel. Their suggestions for overcoming these challenges illustrate a clear understanding of the need to integrate PRC for children and adolescents into the mainstream of current services in the health, police and judicial system, and social services and education sectors. Their suggestions also illustrate the need to close the gap between these services' responses and the community's efforts to prevent VAC and support the children and adolescents who have experienced sexual violence and their families.

POLICE AND JUDICIAL SYSTEM SECTOR

This group discussed the following key components of responses for the police and judicial sector:

- Taking and documenting statements in a nonthreatening, child-focused manner
- Investigating criminal activity
- Acquiring and maintaining chain of evidence
- Ensuring safety of the child
- Prosecuting/adjudicating of the offender
- Preparing witness and providing court support
- Issuing referrals to/from health and support services

Participants in this group described the local-level responses that should take place, though the system seldom functions this way. At police stations where there is a GCD, the police are trained to work with the child and family reporting sexual assault in a sensitive manner. (Participants could only identify three police stations with functioning GCDs.) The police issue a PF3 (a form used by the police and medical services providers) that is sent along with the child to the hospital to be completed by the doctor after the medical/forensic exam. The evidence is sent to the forensic lab for analysis that the police have to pay for up-front. The police also connect the child and the family with Child Protection Services. At the same time, the police performing the aforementioned duties investigate the scene of the crime.

The obstacles faced by the police and the judicial system sector in using the key response components include:

- The community being unaware of the legal processes involved in child sexual abuse cases
- The family's decision to drop the case (child recants, is married off, or moves away)
- Insufficient training for police on how evidence can be collected and preserved and where it should be sent to
- Insufficient police investigation of the crime
- The lack of witness preparation, including preparation of the child
- The lack of witness protection, including the lack of protection in court for children and adolescents who have experienced sexual violence and exploitation.
- The family's inability to handle travel costs to the police station or the court
- Jurisdictional issues with juvenile court

The group suggested that to overcome the obstacles, TV or radio public service messages could be used to make communities aware of legal procedures and police support available in PRC. Assuring that the GCDs are staffed at all police stations as is outlined in the Law of the Child Act would be a useful step in demonstrating effective responsiveness. Coordination at the community level among service providers could be improved. It also would be helpful in particular to increase the number of child protection homes and child-friendly one-stop-centers for care and family justice. All of the professionals involved in the sexual assault response could benefit from additional training, particularly in forensics. Offering more education in life skills at school is also important.

COMMUNITY SECTOR

This group discussed the following key components of responses for the community sector:

- Making the community aware of the scope and impact of child sexual abuse
- Implementing community mechanisms for accessing medical and judicial PRC services
- Ensuring safety/protection of children and family
- Recognizing parental roles and parenting skills
- Encouraging the child to participate in decision making
- Teaching life skills in schools
- Reducing stigma surrounding post-rape reintegration

The obstacles faced by the community sector in using the key response components include:

- Differing social and cultural norms, values surrounding violence against children
- Cultural or societal taboos against reporting perpetrators who are family members

- The lack of youth-friendly services available to community
- The lack of a system to provide safe shelter or child protection homes
- The lack of community trust in institutions and lack of knowledge of legal systems compounded by low literacy levels and poor understanding of laws written in English
- The belief that the community's ways of "resolving" the issues outside of the formal legal system are better

The group suggested overcoming the obstacles by raising awareness of VAC and GBV and reducing stigma through culturally appropriate behavior change communication (BCC) messages in the media. Using more volunteer community members as parasocial workers with local knowledge of local cultures and values to work with trained, qualified social workers could help close the gap between the community and "the system." Access to child-friendly services could be increased through the mapping of services, disseminating of information on child protection services, strengthening of community-based child protection services, and the using of community meetings as a platform for raising awareness of steps that can be taken against VAC and GBV. The group thought it was also important to roll out regulations of the Law of the Child Act and to translate these regulations into Swahili, so they can be easily accessible to the community.

SOCIAL SERVICES AND EDUCATION SECTOR

This group discussed the following key components of responses for the social services and education sector:

- Undergoing assessment for and getting referral to PSS
- Undergoing safety assessment and planning
- Providing safe housing, relocation services, if required
- Reintegrating into family/household, if required
- Providing long-term PSS counseling and rehabilitation
- Receiving referrals from/to police and health sectors
- Raising awareness in community and reducing stigma

Participants concluded that PSS is extremely limited within formal structures. Also, on the whole, there are no adequate interventions or referral sources for children and adolescents who have been assaulted. For acute cases where it is necessary to remove a child from the home, safe houses, drop-in centers, and SAFE Haven services are provided on a very small scale. Some teachers are trained to help children who have been sexually assaulted, and sexual reproductive health is taught in secondary and primary schools. Vocational training centers assist adolescents in becoming self-supporting.

Families provide informal PSS to survivors of sexual assault. Strong efforts are made to reintegrate children and adolescents who have experienced sexual violence into the family household after "cooling-off" periods spent staying with their extended family.

The obstacles faced by the social services and education sector in using the key response components include:

- Lack of definition of PSS and lack of knowledge of how to access and disseminate best PSS practices
- The community preference for solving the issue themselves, within the family, rather than involving the expensive formal legal system
- Limited privacy and confidentiality during police interrogations
- The survivors' insecurity and sense that "they are nobody's children" and that if they complain, they will not have anywhere to go
- The gaps in the child justice system because of high turnover and change of assignments among police officers trained to manage PRC
- An inadequate definition of appropriate placement services for children and adolescents who are in acute danger and the fragmentation of current placement services, which are mostly supported and funded by NGOs
- Community reluctance to talk about VAC and to adequately protect the children
- The perception that schools are not always safe and are not necessarily places where children are taught to recognize inappropriate behavior and boundaries; girls becoming pregnant while in school often have a hard time being accepted back into the school community; Zanzibar working on a program that reintegrates girls who become pregnant into schools after they have given birth
- Children traveling to occupational schools and living in houses that are havens for abuse

The group suggested that to overcome the obstacles the existing social services procedures should be strengthened and expanded. The group also suggested that there should be a shared definition of best practices for referral to services and support in the aftermath of assault. Supporting the district and national teams for community justice facilitation would help close the gap between informal resolution of issues and the legal system. Village leaders, police, community representatives, and NGO members who live in the community could assist with this. Africare, for example, trained villagers how to handle VAC cases. Nongovernmental organizations like the House of Peace, which runs a drop-in center and provides shelter for children and their mothers, could do more with additional formalization of its approaches. In all cases, children's requests should be considered when making reintegration plans. Assuring a permanent GCD officer for each police district would stabilize support for survivors of sexual violence and help build community trust. This could also happen by having teachers and those who work in schools need to demonstrate that they are trustworthy, adhere to a code of conduct, and teach and model life skills to their pupils and students.

HEALTH SECTOR

The group focused on the current situation in Tanzania and identified the status of core components available to health care providers given in the *Technical Considerations* (Table 1, page 5). It also discussed obstacles and gaps in the delivery of child-friendly PRC services.

Key Component	Personal protective equipment (PPE)
Current Status	MOHSW facilities lacking adequate PPE, though PPE more readily available in urban and higher-level facilities
Key Component	History-taking and forensic examination
Current Status	History and examination not routinely done in child-/adolescent-friendly manner
Obstacles	Lack of infrastructure equipment, no child-friendly room Inadequate provider capacity
Key Component	Pregnancy prevention
Current Status	Tools available for capturing service provision Lack of established national parameters for EC
Obstacle	Lack of access to EC medications and local misconceptions (including on the part of the HCW) on the use of EC
Key Component	HIV diagnostic testing and counseling
Current Status	Guidelines and SOPs to guide HIV testing and counseling (HTC) in PRC available HTC fully integrated and majority of sexual violence cases tested by health care providers
Obstacles	Frequent stockout of testing supplies Inadequate forecasting for supplies
Key Component	PEP
Current Status	Guidelines and SOPs to guide PEP provision available PEP not available at all service delivery points countrywide Different models for PEP provision used, delivered in CCs and by health care workers
Obstacles	Inadequate provider capacity Stockouts

Key Component	Sexual health screening
Current Status	Guidelines and SOPs to guide PEP provision available STI training curriculum available Screening fully integrated into other services Pediatric formulas readily available
Obstacles	Stockout of PEP Service providers lacking skills to deal with adolescents with STI and no routine screening of the pre-pubertal age group for sexual abuse
Key Component	Hepatitis B
Current Status	Guidelines and SOPs to guide PEP provision available
Key Component	Tetanus
Current Status	Not offered to survivors routinely
Obstacle	Not part of the essential health commodities in MOHSW
Key Component	Evaluation and treatment of injuries, forensic examination, and documentation
Current Status	Guidelines and SOPs available Training curriculum available, though no standardized pediatric training curriculum for medical forensic exams Data collection tools such as registers and forms not fully operationalized Health care providers trained in documentation in most facilities Police form (PF3) including sexual violence
Obstacles	Inadequate availability of PRC kits Adult curriculum not adequately addressing child and adolescent issues Very few providers to deal with mental health issues in children
Key Component	Trauma counseling
Current Status	Guidelines and SOPs to guide trauma counseling available
Obstacles	Very few trained counselors
Key Component	Referrals to/from police and support system

Current Status	Support systems available, some health care providers and police trained
Obstacles	Lack of shelters that will take children without their mothers Lack of sector linkage systems Knowledge gap on linkages Stigma in community Perpetrators' close relatives Lack of community awareness A preference for community justice systems

RECOMMENDATIONS AND ACTION PLANS

Participants once again worked in four small groups (health care, police and judicial system, social services and the education, and community sectors) to draft action plans and make recommendations on the way forward. (see Appendix C: Action Plans). Each group discussed six components for its action plan, namely:

- Guidelines
- Capacity building of service providers
- Referrals
- Policies and laws
- Commodity and supplies
- M&E

Participants presented the following recommendations contained in the action plans in a plenary session.

Summaries of each group's recommendations are:

GUIDELINES

The participants acknowledged that some guidelines on PRC exist, but these guidelines do not address the needs of children and adolescent survivors of sexual violence. They recommended a desk review of current guidelines as an initial step in developing guidelines for the PRC of children and adolescents. The participants recommended that these guidelines deal with children's rights and the prevention of VAC. They said the guidelines should include sections written especially for GCD police officers, parents, and teachers and discuss the community's role in child protection and community options for accessing PRC services.

CAPACITY BUILDING OF SERVICE PROVIDERS

Participants expressed strong appreciation for trained service providers, but they noted that their numbers are few. Participants strongly recommended a review of the current curricula and the development or expansion of existing training programs. Participants also recommended that the

roll out of the new guidelines on PRC for children and adolescents should be accompanied by Training of Trainers workshops delivered by experienced trainers. It was recommended that the training should cover PRC, VAC, GBV, and child protection and should be provided to medical providers, law enforcement and prison authorities, social workers, community leaders, parents, and teachers. The trainings should focus on PSS and contain practical information for the public on how to access PRC services.

The following model was suggested for the development of culturally appropriate PRC guidelines and training for service providers and civil society on PRC for children and adolescents. Participants strongly recommended an inclusive multi-sectoral approach that avoids duplication of materials.

Steps for Developing Guidelines and Training on PRC for Children and Adolescents

1. Conduct desk review of current curricula related to VAC and PSS being used a) in Tanzania and b) elsewhere in East and Southern Africa.
2. Conduct desk review of training programs related to VAC and PSS being used a) in Tanzania and b) elsewhere in East and Southern Africa.
3. Form a small technical working group to plan the road map (involving representatives from ministries, NGOs, and civil society).
4. Develop terms of reference for consultant and consultant engagement.
5. Hold multi-sectoral stakeholder fora to gather field experiences that will inform the adapting of technical guidelines into local context.
6. Conduct several follow-up meetings between consultant and technical working group for developing content in the guidelines.
7. Circulate to relevant stakeholders for review.
8. Validate guidelines.
9. Disseminate guidelines.
10. Develop training curricula and sensitization packages using appropriate training methodologies to reflect the content in new guidelines on PRC for children and adolescents.
11. Provide TOT to develop team of multi-sectoral “champions” in PRC for children and adolescents.
12. Pilot training curriculum and make necessary adaptations.
13. Scale up provider trainings across country.
14. Monitor and evaluate the whole process.

REFERRALS

To avoid stove-piping and in some cases duplication of services, participants recommended that national guidance be developed that speaks to referral linkages. Coordinated guidelines should address access to multi-sectoral PRC services, sensitize care providers, and strengthen systems that respond to community PRC needs. The linkages among social welfare officers, hospital social workers, parasocial worker volunteers, law enforcement officers, and civil society should be made clear.

POLICIES AND LAWS

Participants unanimously recommended that laws be reformed to address contradictions relating to the age of marriage; translate into Swahili, develop, and disseminate regulations for the Law of the Child Act; develop and disseminate a national plan for PRC for children and adolescents; identify examples of “model” bylaws that protect children; and develop BCC messages in support of policies providing protection to children.

COMMODITIES AND SUPPLIES

Participants from the health sector recommended strengthening the supply chain system. Participants from the social services and education sector recommended government provision of temporary housing for children at risk. The community group advocated for the empowerment of communities, so they could support demands for local child-friendly facilities and PRC kits in dispensaries.

MONITORING AND EVALUATING

The health sector group recommended finalizing the health information system review to incorporate VAC indicators. The community group recommended developing simple user-friendly M&E tools, so communities could be involved in data collection and the conducting of surveys to measure community members’ satisfaction of PRC services for children and adolescents.

APPENDIX A

COMMUNITY ACTION PLANS

ACTION PLAN FOR PRC—HEALTH SECTOR

	TARGET POPULATION	GAPS	ACTION	STAKEHOLDERS	EXTERNAL TA NEEDS	TIMELINE
Policies and laws in place that protect adolescents and children	Community health care providers, implementing partners, developing partners	Operationalization of policy guidance	National dissemination plan	Ministry of Health, multisectoral task force members, implementing partners	Fund	3 years
					Capacity building of policy makers	
National guidelines and protocols	Health care providers, implementing partners, developing partners	Guidelines do not adequately address adolescent and children issues	Review existing guidelines to expand on adolescent and children issues	Ministry of Health, multisectoral task force members, implementing partners	Technical support for development of guidance	2 years
					Financial resources - stakeholders, consultant	
Capacity building	Health care providers	Lack of curriculum for violence against children	Develop training curriculum for violence against children	Ministry of Health, multisectoral task force members, implementing partners	Technical support for curriculum development	3 years
	Social welfare	Lack of skilled trainers	Trainings of trainers		Financial resources - stakeholders meeting, consultants	
	Implementing partners		Train health care providers			
	Members of task force		Advocate for pre-service training			
Community health workers	Sensitization package					
Supply chain management	Health care providers	Provider capacity in use of commodity supply systems	Train health care providers in use of commodity supply systems	Ministry of Health; ministries, departments, and agencies; SCMS	TA from experts on supply chain management	3 years
	MSD staff	Erratic supply of commodities	Strengthen the national supply chain management systems			

Referral linkages	MDAs, nongovernmental organizations, community-based organizations, developing partners	No national guidance that speaks to referral linkages	Develop national guidance that speaks to referral linkages	Prime Minister's Office Regional Administration and Local Government; ministries, departments, and agencies	Technical support for curriculum development	3 years
		No national multisectoral referral tools	Develop national multisectoral referral tools		Financial resources - stakeholders meeting, consultant	
		No multisectoral training curriculum	Develop a multisectoral training curriculum			
Monitoring and evaluation	Health care providers, implementing partners, developing partners, councils	Violence against children not included in health information systems	Finalize the health information systems review to incorporate violence against children indicators	Ministry of Health, multisectoral task force members, implementing partners	Technical support for curriculum development	5 years

NEXT STEPS

1. Form a small technical working group to path the road map
2. TORs for consultant and consultant engagement
3. Hold stakeholder forum to get field experiences that will inform adapting technical guidelines into local context
4. Several follow up meeting for developing content into the guidelines
5. Circulate to relevant stakeholders for review
6. Validation of guidelines
7. Dissemination of guidelines
8. Review training curriculum and develop sensitization package to reflect the content in new guidelines
9. Train TOTs
10. Pilot training curriculum
11. Scale up provider trainings across country
12. Monitoring and evaluation of the whole process

ACTION PLAN FOR PRC—COMMUNITY

	COMMUNITY STRENGTHS	ACTION	STAKEHOLDERS
Traditions and cultural norms in place to protect adolescents and children	Bylaws (applied at local level) understood by community.	<ul style="list-style-type: none"> • Support development, application of child protection bylaws. • Express laws in simple language. 	<ul style="list-style-type: none"> • Ward committees • Community police • Lawyers who write bylaws • Legal service organizations
	Self-help groups and faith-based organizations – with strong values in place	<ul style="list-style-type: none"> • Access groups and faith-based organizations to strengthen knowledge & skills in violence against children, youth and child protection 	<ul style="list-style-type: none"> • Self-help group leaders • Parents • Religious leaders
	Positive community norms in place	<ul style="list-style-type: none"> • BCC to reinforce positive behavior and reduce harmful behaviors 	<ul style="list-style-type: none"> • Community • Children • Youth
National guidelines and protocols	Law of the Child Act	<ul style="list-style-type: none"> • Translate, disseminate, operationalize Child Act in community 	<ul style="list-style-type: none"> • Community • Children • Youth
Capacity building of service providers	Community leaders - e.g., teachers, nurses, police - have responsibility and influence	<ul style="list-style-type: none"> • Use community platforms, schools, dispensaries to provide child rights training and raise awareness • Harmonize committee messages on Child Rights • Social welfare officers to provide long term care and psychosocial support to survivors of rape. 	<ul style="list-style-type: none"> • Local committees
Commodity and supplies	Communities contribute to building of dispensaries, etc.	<ul style="list-style-type: none"> • Make dispensaries child friendly • Advocate for equipment for PRC 	
Referral and linkage to other service providers	Community members want to get help	<ul style="list-style-type: none"> • Create awareness of choices/options among steps procedures to access services (formal and informal) • Coordinate guidelines on access to PRC services, sensitize care providers and strengthen systems that respond to community PRC needs 	<ul style="list-style-type: none"> • Village Executive Officer • Ten-cell leader • Police (if available) • Multiple channels of service providers
Monitoring and evaluation		<ul style="list-style-type: none"> • Harmonize data collection at the village level • Develop simple community-friendly M&E tools • Use meetings at ward levels to track whether the child protection system is working, use data for decision making at the community level 	<ul style="list-style-type: none"> • Police (Gender and Children’s Desk) • Dispensary

NEXT STEPS AND WAY FORWARD

1. Improve dissemination of laws, policies, guidelines and procedures in PRC and protection of children and adolescents at the community level.
2. Promote and advocate for community members, women, children and adolescents to have a voice when developing and implementing guidelines that will work at the community level.
3. Ensure that the entire community, including men as fathers and husbands, is positively engaged in preventing violence against children and gender-based violence and protecting children and adolescents
4. Promote child and youth protection as a mainstream, cross-cutting issue in all sectors.
5. Standardize multi-sectorial approach and harmonize PRC guidelines and procedures for services.

ACTION PLAN FOR PRC—JUSTICE SECTOR

	TARGET POPULATION	CHALLENGES	ACTION	STAKEHOLDERS	EXTERNAL TA NEEDS	TIMELINE PLANNING IMPLEMENTATION MONITORING
Policies and laws in place and protect the adolescents and children	Children	<ul style="list-style-type: none"> • Talks about children <18 • Provides exceptions that include children who are married • Law allows marriage at 14 years but no sex until 15 years • Men must be 18 before marriage • Human rights document does state girls should be 18 before marriage, not ratified so not in Tanzanian law • must prove penetration for a rape conviction • expectation of Injury with penetration • War (?) tribunal (tribal court) focus on reconciliation versus criminal action • perpetrator can influence the tribunal/law enforcement 	Law reform (laws that are contradictory) (push for law ratification)	<ul style="list-style-type: none"> • Ministry of constitution and justice affairs • Parliamentarians • Representation from disciplines who can speak to the issues • NGOs- especially those dealing with women's issues 	(Is there a UN commission that could assist?)	2 year timeframe for implementation

<p>National guidelines and protocols</p>		<ul style="list-style-type: none"> • there is a standard operating procedure for gender desk law enforcement • challenge that there is not yet a gender desk in every district • gender desk is not covered 24 hours a day • gender desk is also assigned other duties • police assigned gender desk are not respected due to their dealing with gender issues • sometimes cases are assigned away from the gender desk when it is in the best interest of the perpetrator • There is no protocol to move the evidence from the patient at the hospital to the gender desk • Training on the PF3 form • Issues with interpreting form info into Swahili • Police corruption issues 	<ul style="list-style-type: none"> • Training of Head of police • Police inside and out of the gender desk • Orientation training for all individuals within systems who might interact with the victim • Advocate for more training on how to complete PF3 for medical and police • Stock new PF3 forms at medical facilities that provide exams • Contemplate police on duty at hospitals • Tools in place for law enforcement in how to and when to respond to hospitals • Review of curriculum (legal and medical) by content expertise (ministry of science and technology and/or health for paramedicals) 	<ul style="list-style-type: none"> • Minister of health should coordinate • Minister of justice • Head of the Gender based officers • Chief Justice • Local government authorities 		
<p>Capacity building of service providers</p>		<ul style="list-style-type: none"> • need mentorship and technical assistance on the ground for medical providers and law enforcement • the police budgets do not specify gender based work so it is not given priority 	<ul style="list-style-type: none"> • Increased training of gender based officers on response and investigation • Institution of offender treatment options (for juveniles and adult offenders) 		<ul style="list-style-type: none"> • External vetting of curriculum through experts (law enforcement and medical) to ensure correlation 	

		<ul style="list-style-type: none"> • cost for transport to LE • cost for PF 3 • cost for medical exam • new PF3 form, police insisting that old form get completely used prior to instituting new one 			with expected minimum standards	
Commodity and supplies						
Referral and linkage to other service providers		<ul style="list-style-type: none"> • social welfare officer is responsible and has no safe homes. welfare officer may keep the child with her • perpetrator may harm the welfare officer • orphanages don't take kids over 10 years old • don't have temporary shelter etc. • not enough social welfare officers necessary 	<ul style="list-style-type: none"> • Involving education in training on process of what to do • Utilize hospital social workers as extensions of the social welfare officer to respond to CSA • Para-social worker volunteers in communities acting as an arm of social welfare officer • Comprehensive health plans • Strengthen the temporary homes that do exist for children who are removed (government owned) 	<ul style="list-style-type: none"> • CHMT • Health Center Committee • Dispensary Committee • Community Development Officers • Social workers and para-social workers • Child protection teams (MVCC) 		
Monitoring and evaluation						

ACTION PLAN FOR PRC—SOCIAL WORK AND EDUCATION

	LIST/NEED	TARGET POPULATION	CHALLENGES	ACTIONS	STAKEHOLDERS	EXTERNAL TA NEEDS	TIMELINE PLANNING IMPLEMENTATION MONITORING
<p>Policies and laws in place and protect the Adolescents and children</p>	<p>E: -Law against corporal punishment- outlines punishment guidelines- under review -Teacher's code of conduct and ethics in place -Education policy allowing girls to attend even if pregnant- should not be denied -Law of the child act- not specific to schools and disseminated</p> <p>NEED E: Policy in place for safety of children during transportation NEED E: Policy for regulation of Hostels where children stay while they attend school</p> <p>NEED E: screening</p>	<p>E-Teachers Ministry of Education Minister</p>	<p>E: children living far away from home to attend school in homes that are not safe</p> <p>E: Parents and legislators are unaware of the risks that kids are placed under in the places they are sending them to</p>	<p>Focus on the decision makers at the National Level to make legislative changes necessary for child protection, as described.</p>	<p>-Ministry of Health -Ministry of Education -Teachers/Tanzanian Teachers Associations -Commission for Universities -Minster of Constitution and Legal Affairs -Minister of Youth Faith Based Organizations</p>	<p>Financial</p> <p>Look for Best practices and models from other countries in this area</p>	<p>Advocacy plan for interaction and presentation to Education Minister</p> <p>Stakeholder meeting for Education sector, including listed stakeholders on VAC</p> <p>Have them come up with plan to address the issues outlined- including safety and accountability for VAC</p>

	process for child workers- like bus drivers, teachers, hostel						
	<p>Social Services : Existing: Law of the child act, and children's development policy NEED: Operationalization and revision of the Law of the Child Act and the Law of the Marriage Act</p>	Community Children and parents, families	<p>Regulations drafted but not being enacted</p> <p>Tied up at the judiciary level</p>	Multi-sectoral task force is following the legislation- but it was submitted a year ago- continue to follow up with that- Social Welfare Department	Minister of Health and Social Welfare Department of Social Welfare Minister MCDGC Ministry of Constitution and legal Affairs Minister of Home Affairs	None	
National guidelines and Protocols /SOP	<p>E:currently family/lifeskills Ministry of Health has a draft Parent Education guide NEED: funding for Parent Education Guide for Education based and violence prevention from MOH NEED E: Expand the Parent Guide to include issues of violence prevention in children and child rights</p>	Parents	<p>Funding for any revisions that need to take place Funding for printing and dissemination of materials</p>	Involve stakeholders in the dissemination plan of materials	Minister of Health Minister of Education Minister of Youth	Sample parent education for VAC, recognition, risk reduction	Planning
Capacity building of service	Existing: School based intervention programs- NEED to	Students	Social acceptance- may be parental resistance	Communicate to parents and at the	Parents Community NGOs	Support for curriculum revision to	

	<p>Social Services: There is a strategy in place to increase the social welfare force in TZ. The Law of the Child will make it so that social services is supposed to manage children.</p> <p>NEED: Very few social service workers are available- human resource is very limited.</p> <p>NEED: There is a lack of public awareness of the importance of Social services and their role at the local level</p> <p>NEED: At the implementation level there is no structural set up for Social services, it is under other departments community development department</p>		<p>play, there is no value Historically has been passed back and forth between Ministry or department level with administrative changes.</p>				
				Champion or advocate Support at the community level and at the higher levels of government	Minister of Health and Social Welfare Minister of Public Service	Adopt the Zanzibar model- they use a Minister of Social Welfare, children and women- their allotment	
Commodity and supplies	Need: Training materials and instructors	Children who have been abused	Perhaps the lack of intact social services systems	Government should purchase	Minister of Education Minister of Social Welfare		

	<p>Social Welfare: Currently have limited drop in services, only 1 safe house, 1 drop in center only- NEED: Lack of availability of temporary or shelter services for children at risk or abused NEED: No psychologists in TZ- they are not recognized or included in the government system</p>		<p>is a contributing factor to this. When children who are abused have no place to go, they are placed sometimes into residential homes</p>	<p>temporary safe houses and shelters</p>			
Referral and linkage to other service providers	<p>Need: -for parent education on sexual violence in children- perhaps this might be best accomplished by someone other than the teachers- possibly even have this education at well baby clinics, reproductive health clinics* have the community invested in the process*</p>						
Monitoring and evaluation							

APPENDIX B

MEETING AGENDA



Building Capacity on Post-Rape Care for Children and Adolescents Technical Workshop

Dar es Salaam, Tanzania
September 4-5, 2013

Day 1: September 4, 2013

- | | |
|----------------------------|---|
| 8:30 AM – 8:45 AM | Registration |
| 8:45 AM – 9:15 AM | Welcome/Opening
Erick Mlanga, <i>U.S. Agency for International Development (USAID)/Tanzania</i>
Dr. Georgina Msemo, <i>Director of Preventive Services, Ministry of Health and Social Welfare (MOHSW)</i> |
| 9:15 AM – 9:30 AM | PRC Workshop Overview and Objectives
Brenda Bowman, <i>AIDSTAR-One</i> |
| 9:30 AM – 10:00 AM | Current Guidelines, Experiences and Challenges to Providing Post-Rape Care in Tanzania
Dr. Grace Mallya, <i>National Coordinator of Gender and Reproductive Health, MOHSW</i> |
| 10:00 AM – 10:30 AM | Coffee/Tea Break |
| 10:30 AM – 11:00 AM | Policies, Implementation and Challenges to Providing Post-Rape Care in Tanzania
Mustafa Kudrati, <i>Country Director, Pathfinder</i>
Dr. Samuel Likindikoki, <i>Lecturer, Muhimbili University of Health and Allied Sciences</i>
Dr. Rose Lesser, <i>Program Manager, Pathfinder</i>
Dr. Witness Motta, <i>Senior Technical Advisor, Engender Health/RESPOND</i> |
| 11:00 AM – 11:45 AM | Q&A/Group Discussion
Moderated by Brenda Bowman, <i>AIDSTAR-One</i> |
| 11:45 AM – 12:15 PM | An Overview of The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs |

Jennifer Weeks, Project Director, *International Association of Forensic Nurses (IAFN)*
Kim Day, SAFE Technical Assistance Coordinator, *IAFN*

- 12:15 PM – 1:00 PM** **Q&A/Group Discussion**
Moderated by Brenda Bowman, *AIDSTAR-One*
- 1:00 PM – 2:00 PM** **Buffet Lunch**
- 2:00 PM – 2:15 PM** **Medical Forensic Management of Post-Rape Care for Children and Adolescents**
Dr. Felix Kisanga, Lecturer, *Muhimbili University of Health and Allied Sciences*
Dr. Projestine Muganyizi, Lecturer, *Muhimbili University of Health and Allied Sciences*
- 2:15 PM – 2:30 PM** **The Kenya Experience: Providing Post-Rape Care for Children and Adolescents**
Dr. Lina Obonyo, Care and Treatment Manager, *Liverpool VCT Care and Treatment Center*
- 2:30 PM – 2:45 PM** **Q&A/Group Discussion**
Moderated by Brenda Bowman, *AIDSTAR-One*
- 2:45 PM – 4:00 PM** **Tea and Breakout/Small Group Discussions: Experiences and Challenges to Providing Post-Rape Care for Children and Adolescents in Tanzania**
Moderated by Brenda Bowman, *AIDSTAR-One*
- 4:00 PM – 4:30 PM** **Report Back From Breakout/Small Group Discussions and Q&A**
Moderated by Brenda Bowman, *AIDSTAR-One*
- 4:30 PM – 4:45 PM** **Day I Recap and Closing Session**
Elizabeth Lema, Community Care SRU Lead, *USAID/Tanzania*
Brenda Bowman, *AIDSTAR-One*

Day 2: September 5, 2013

- 8:30 AM – 9:00 AM** **Welcome and Day 2 Objectives**
Brenda Bowman, *AIDSTAR-One*
- 9:00 AM – 9:15 AM** **A Practitioner's Perspective: Addressing the Needs of Children and Adolescents Who Have Experienced Sexual Violence**

Dr. Margareth Makuchilo, Medical Officer Temeke Municipality,
Dar es Salaam

- 9:15 AM – 9:30 AM** **Psychosocial Interventions, Follow-Up Care, and Referrals**
Divina James, Regional Training Officer, *Regional Psychosocial Support Initiative (REPSSI)*
- 9:30 AM – 10:00 AM** **Q&A/Group Discussion**
Moderated by Brenda Bowman, *AIDSTAR-One*
- 10:00 AM – 10:30 AM** **Coffee/Tea Break**
- 10:30 AM – 1:00 PM** **Breakout/Small Group Discussions: Action Planning for Developing Post-Rape Care Guidelines (in line with current country guidance) for Tanzania**
Moderated by Brenda Bowman, *AIDSTAR-One*
- 1:00 PM – 2:00 PM** **Buffet Lunch**
- 2:00 PM – 3:30 PM** **Groups Present Action Plans/Next Steps for Developing Post-Rape Care Guidelines for Tanzania**
Moderated by Brenda Bowman, *AIDSTAR-One*
- 3:30 PM – 4:00 PM** **Q&A/Group Discussion and Way Forward**
Erick Mlangi, *USAID/Tanzania*
- 4:00 PM – 4:15 PM** **Closing Remarks**
Dr. Georgina Msemo, Director of Preventive Service, *MOHSW*

For more information, please visit aidstar-one.com.

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