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PEPFAR EXPERT MEETING ON CLINICAL POST-RAPE CARE FOR CHILDREN IN PRIMARY HEALTH CARE CENTERS THAT PROVIDE HIV CARE

WASHINGTON DC, APRIL 26, 2012
SUMMARY REPORT



AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

JULY 2012

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AIDS Support and Technical Assistance Resources Project

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Cover photo

Photos from a presentation given at the meeting by the Great Nelspruit Rape Intervention Program, South Africa. Images depict a field visit and donated teddy bears.

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INTRODUCTION AND BACKGROUND

Both the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Health Initiative have made monitoring and responding to gender-based violence a key focus, particularly with regard to strengthening post-rape care services. These include the provision of HIV post-exposure prophylaxis, screening and counseling for gender-based violence, and strengthening linkages among health, legal, law enforcement, and judicial services and programs to mitigate gender-based violence.

There has also been an increased focus on and concern about sexual violence against children. The PEPFAR Gender Based Violence Initiative, which ended in 2010, strengthened post-rape care services in primary health centers in Uganda and Rwanda.¹ Results from this initiative indicated that a large proportion of patients presenting for care were under 18 years of age, yet the services were not tailored to the special needs of these age groups. These data confirm what is anecdotally known to be quite widespread in Africa. Barriers to services for child survivors include: issues around confidentiality; inadequate availability of post-exposure prophylaxis; a lack of training for providers in post-rape care protocols for children (where these exist); and lack of resources. Another barrier is insufficient collaboration in the response to sexual and gender-based violence between the medical, legal, and policy sectors and with community-based structures (including child protection entities) that can play a critical link in identifying at risk children and adolescents as well as offer psychosocial and other support beyond clinical care.²

There is limited guidance on provision of post-rape care services for persons under 18 years of age. The East, Central, and Southern African Health Community (ECSA-HC) released guidelines for the clinical management of child sexual abuse in July 2011.³ Although the World Health Organization (WHO) Africa Regional Office was involved in the development of the ECSA-HC guidelines, to date, WHO has not produced its own clinical guidelines specifically for children. While there are many examples of local institutions that are addressing post-rape care for children and adolescents—for example, in Kenya, South Africa, Zambia, and Zimbabwe—PEPFAR has not provided systematic information or guidance to its implementing partners on this issue.

MEETING OVERVIEW

In response to this gap, the PEPFAR Gender, Orphans and Vulnerable Children, and Pediatric Treatment Technical Working Groups, in coordination with the Together for Girls partnership, convened a one-day expert meeting in Washington, DC, on April 26, 2012, to develop technical considerations on post-rape care for persons under 18 years of age in primary health centers that also provide HIV care. The objectives of this meeting were to:

- Develop key recommendations for the delivery of post-rape care in primary health centers for those under 18 years of age

¹ Keesbury, Jill, and Jill Thompson. 2010. *A Step-by-Step Guide to Strengthening Sexual Violence Services in Public Health Facilities: Lessons and Tools from Sexual Violence Services in Africa*. Washington, DC: U.S. Agency for International Development. Available at www.popcouncil.org/pdfs/2010HIV_PEPFAR_SGBV_Toolkit.pdf (accessed August 2012).

² Kilonzo, Nduku, Njoki Ndung'u, Nerida Nthamburi, Caroline Ajema, Miriam Taegtmeier, Sally Theobald, and Rachel Tolhurst. 2009. Sexual Violence Legislation in Sub-Saharan Africa: The Need for Strengthened Medico-legal Linkages. *Reproductive Health Matters* 17(34):10-19.

³ ECSA-HC. 2011. *Guidelines for the Clinical Management of Child Sexual Abuse*. Arusha, Tanzania: ECSA-HC. Available at http://africahealth2010.aed.org/PDF/CSA_Guidelines_09_2011.pdf (accessed May 2012).

- Review and build upon existing guidelines and documents, including the ECSA-HC guidelines and the adult-focused WHO guidelines for medico-legal care for victims of sexual violence^{4, 5}
- Develop technical considerations on delivery of post-rape care in primary health centers for those under 18 years of age, specifically to inform PEPFAR, and for use by other partners and implementers more broadly.

The technical meeting brought together 28 people including PEPFAR U.S. Government and Together for Girls representatives, as well as experienced providers (clinicians, behavioral scientists, and social workers) with expertise in child protection; sexual exploitation and abuse; care for survivors of violence; emergency pediatrics; child-focused clinical services; HIV prevention, care and treatment; fistula treatment; and distribution of post-exposure prophylaxis for HIV. Participants represented seven countries⁶ and 14 organizations.⁷ (For a detailed agenda and complete list of participants, see Appendices I and II.)

MAJOR HIGHLIGHTS

BRIDGING THE GAP BETWEEN THE ASPIRATIONAL AND THE ACHIEVABLE

A brief overview of major barriers to providing comprehensive care for survivors of sexual violence was provided at the beginning of the meeting. The discussion underscored the reality: in resource-poor settings, comprehensive care for survivors of sexual violence that includes medical, legal, and social support remains a challenge. Major barriers include:

- A lack of consistent protocols
- A lack of training for health providers
- Need to strengthen capacity, comfort, and understanding around the specific unique needs of children including, for example: communication with children and adolescents; forensic data collection; medical exams and treatment including dosaging; and legal issues related to treating children
- Weak links between the medical and legal sector, particularly with regard to national reporting requirements and local laws
- Inconsistent definitions of what it means to provide child-friendly services
- A disconnect between sexual trauma and HIV/sexually transmitted infection testing and follow-up.

⁴ WHO 2003. *Guidelines for Medico-legal Care for Victims of Sexual Violence*. Geneva: WHO. Available at <http://whqlibdoc.who.int/publications/2004/924154628X.pdf> (accessed May 2012).

⁵ These guidelines are currently being revised.

⁶ Democratic Republic of Congo, Kenya, Mozambique, South Africa, United States, Zambia, and Zimbabwe.

⁷ U.S. Centers for Disease Control and Prevention; EnCompass LLC; Emory University School of Medicine; Family Support Trust Clinic; Great Nelspruit Rape Intervention Program; John Snow, Inc.; Liverpool VCT, Care & Treatment; Livingston Pediatric Center of Excellence; Office of the U.S. Global AIDS Coordinator; Panzi Hospital/Panzi Foundation; Together for Girls; United Nations Children's Fund; U.S. Agency for International Development, Office of HIV/AIDS; U.S. Agency for International Development representatives from Mozambique and Lesotho; and the Government of Mozambique (Ministry of Health).

Recommendations for overcoming these barriers were provided and included the need for: more training of medical providers; greater linkages between medical, legal, psychosocial support, and community services for comprehensive care; improved follow-up care; and primary prevention and awareness education to shift social norms. The group was then challenged to move beyond the aspirational and think about how to reach the achievable in terms of service provision for survivors of sexual violence in low-resource settings.

UNDERSTANDING THE REALITIES ON THE GROUND: PERSPECTIVES FROM SERVICE PROVIDERS IN AFRICA

Five experts working in service delivery organizations in the Democratic Republic of Congo, Kenya, South Africa, Zambia, and Zimbabwe shared their insights and experience providing post-rape care services for children. Their presentations included a snapshot of the unique needs and challenges service providers face, lessons learned from implementation, and promising practices and recommendations for improving service provision. (See Appendix III for a link to the full presentations.)⁸

Common challenges and gaps mentioned by several of the experts included:

- A lack of trained medical providers and frequent turnover of the few staff who are trained
- Poor referral systems and continuum of care
- Low community awareness of care and treatment options for survivors
- Drug shortages resulting in provision of substandard care
- Gaps in psychosocial support
- Poor linkages between the medical and legal sectors, including a lack of trained court liaison officers.

The experts agreed that comprehensive guidelines on the management of care for children who have experienced sexual violence are greatly needed and would be welcomed by practitioners in the field. These should include specific guidance on the medical management of sexual violence, forensics management, and psychosocial support.

INPUT AND RECOMMENDATIONS FOR TECHNICAL CONSIDERATIONS

Most of the meeting was dedicated to a careful review of a draft of the technical considerations provided to participants prior to the meeting and prepared by the planning committee based on the ECSA-HC and WHO guidelines. Participants came prepared with detailed feedback, suggestions, and recommendations to strengthen and improve the technical content and flow of the document based on experiences providing these services.

Several key issues and concepts raised throughout the meeting included the following:

⁸ In addition to presentations during the meeting, the field-based experts from Kenya, South Africa, Zambia, and Zimbabwe held a panel presentation the following day in Washington, DC to share in more detail to a wider audience some of their experiences working on post-rape care services for children.

Medical care as part of a comprehensive response system: While participants understood that the technical considerations are specifically aimed at medical providers and focus on the provision of clinical post-rape care for children, there was overall consensus that the document should clearly articulate how the medical component is implemented and linked to a comprehensive response system.

Given the limitations of the document, a recommendation was made to PEPFAR to consider developing an additional resource that would include guidance tailored to address the special needs of children for other critical services needed for a comprehensive response, such as psychosocial care, legal and judiciary support, and security, as well as specific training tools and job aids for medical providers. It was further recommended that any tools/guidance should build upon existing materials.

Clear and consistent use of appropriate terminology: A robust discussion ensued about the use of certain terms such as “survivor” versus “victim,” and “sexual violence” versus “child sexual abuse” versus “rape.” Participants shared varied opinions that reflected the challenges in addressing such a complex issue as violence against children. It was also noted that the divergent opinions about terminology are mirrored in the larger child protection/gender-based violence community.

Obtaining consent from children: Much time was spent discussing how to obtain consent from children. Participants recommended that the document include guidance on how to handle specific circumstances, such as:

- How to obtain consent if the caregiver is suspected of being the perpetrator of the abuse
- Determining when it is necessary to obtain consent from a caregiver and when a child’s consent is sufficient
- What to do if a child presents at the clinic on his/her own without being accompanied by a caregiver, and what to do if the child is accompanied by another minor
- How to obtain consent from children with disabilities.

Tailoring care for children based on age and development level: A general concern raised by participants was the need to ensure that the document includes parameters for care based on the age and development level of the child survivor presenting for services. Age differentiation was particularly relevant for sections on obtaining consent from children, identifying physical and behavioral signs and symptoms of sexual violence in children, and communicating with children and taking their history.

Sequencing and flow of chapters/sections: Participants observed that the structure and flow of the document needed careful review to ensure that the sequencing of chapters and sections, particularly those that cover conducting physical examinations and collecting forensic evidence, is in line with the actual process followed by medical providers. Participants made suggestions about how to restructure certain sections and recommended that an experienced practitioner review the document flow and structure.

Special considerations for extremely vulnerable populations: Participants acknowledged the absence of language about the special needs of particularly vulnerable populations, such as mentally and physically disabled children, refugee and displaced children, children who have been trafficked, and migrants. A recommendation was made to mainstream and incorporate specific language on these circumstances throughout the document.

Linkages between sexual violence and other forms of violence: Participants noted that if a child has experienced one form of violence (sexual, physical, or emotional), it can often be an indicator that other violence has occurred as well. Participants agreed that medical providers are not trained on this important issue and recommended adding a section on identifying physical abuse into the document.

Follow-up care and linkages between medical providers and community services: There was general agreement that the role of the medical provider in follow-up care for psychosocial support and other community services is critical. Participants recommended that the document highlight the linkages between medical services (e.g., clinics) and community support structures and the specific roles both medical providers and communities play in follow-up care for children who have experienced sexual violence.

NEXT STEPS

DRAFTING THE NEXT VERSION OF THE TECHNICAL CONSIDERATIONS

The meeting enabled a rich dialogue on the document's strengths and addressed sections that required improvement and elaboration. Based on specialized input, recommendations, and feedback received both during and immediately after the meeting, a revised draft of the technical considerations will be developed. This second draft will be circulated to all meeting participants for further review and revisions. Feedback received will be incorporated into a final draft version and reviewed for accuracy and relevance by local service providers as part of a broader, more formal process for final approval as PEPFAR technical considerations.

TAKING THE TECHNICAL CONSIDERATIONS TO TWO COUNTRIES

Using the draft technical considerations from the expert meeting, the AIDSTAR-One project will help Lesotho and Mozambique make these technical considerations on comprehensive clinical post-rape care services for children more feasible, relevant, and operational in-country and more widely. The scope of work for the activities is still under discussion, and may include initial assessment of current activities and/or the development of complementary tools and materials to further enable activities between the community and facility.

These activities will prioritize learning related to clinical care in the context of the broader package of services needed by children experiencing sexual violence. The association and interplay between gender-based violence and HIV services, as well as community-based and structural interventions needed to address harmful gender norms and build social cohesion for children vulnerable to sexual abuse and rape, will be taken into account.

APPENDIX I: MEETING AGENDA

PEPFAR EXPERT MEETING ON POST-RAPE CARE FOR CHILDREN IN PRIMARY HEALTH CENTERS THAT PROVIDE HIV CARE

APRIL 26, 2012

1201 15TH STREET, NW, WASHINGTON, DC 20005

Meeting Objective: To develop technical considerations for the delivery of post-rape care for persons under the age of 18 in primary health care to inform work in PEPFAR specifically, and more broadly work of other partners and implementers.

Meeting Deliverable: Draft framework for technical considerations with a plan of action.

Meeting Outcomes:

- Summary report highlighting discussions, recommendations, and next steps
- Document: Technical considerations to scale up delivery of post-rape care services for PEPFAR and implementing partners.

Methodology: Facilitated group discussion and presentations.

8:15–8:30am	Registration and Continental Breakfast
8:30–8:45am	Welcome and Introductions Speakers: <i>Gretchen Bachman, U.S. Agency for International Development (USAID)</i> <i>Diana Prieto, USAID</i> <i>Michele Moloney Kitts, Together For Girls</i>
8:45–10:00am	Session 1: Summary of Current Models and Country Presentations with Group Discussion Facilitator: <i>Kate Brookmeyer, U.S. Centers for Disease Control and Prevention (CDC)</i> Speakers (in no particular order): <i>Barbara Kenyan, Great Nelspruit Rape Intervention Program, South Africa</i> <i>Valerie Tagwira, Family Support Trust Clinic, Harare Hospital, Zimbabwe</i> <i>Derrick Saialondwe, CSA Coordinator Livingston Pediatric Centre of Excellence, Zambia</i> <i>Lina Digolo, Liverpool VCT, Care & Treatment, Kenya</i> <i>Christine Amisi, Panzi Hospital, Democratic Republic of Congo</i>
10:00–10:15am	Coffee Break

- 10:15–12:30pm **Session 2: Technical Considerations for Developing Post-Rape Care Guidelines in Relation to PEPFAR’s Work**
Facilitators:
Daniela Ligiero, Senior Gender Technical Advisor, Office of the U.S. Global AIDS Coordinator
Emilia Koumans, CDC
- 12:30–1:00pm **Lunch Break**
- 1:00–3:15pm **Session 2: Technical Considerations for Developing Post-Rape Care Guidelines in Relation to PEPFAR’s Work**
Facilitators:
Gretchen Bachman, USAID
Monique Widnyono, USAID
- 3:15–3:30pm **Coffee Break**
- 3:30–5:00pm **Session 3: Way Forward and Next Steps**
Facilitators:
Diana Prieto, USAID
Nicole Behnam, Department of State or Maurey Mendenhall, USAID

APPENDIX II: PARTICIPANT LIST

Name	Organization
Christine Amisi	Panzi Hospital, Democratic Republic of Congo/Panzi Foundation
Gretchen Bachman	Orphans and Vulnerable Children Technical Working Group
Nicole Behnam	Orphans and Vulnerable Children Technical Working Group
Lilly Bertz	Gender Technical Working Group
Erin Broekhuysen	John Snow, Inc./AIDSTAR-One
Kathryn Brookmeyer	Gender Technical Working Group
Daniel Cothran	John Snow, Inc./AIDSTAR-One
Lindsey Davis	Gender Technical Working Group
Lina Digolo	Liverpool VCT, Care & Treatment, Kenya
Mary Ellen Duke	U.S. Agency for International Development Mozambique
Lynne Franco	EnCompass LLC/AIDSTAR-One
Sarah Karmin	United Nations Children's Fund HIV/AIDS Team
Barbara Kenyon	Great Nelspruit Rape Intervention Program, South Africa
Jennifer Kim	Together for Girls
Marcy Levy	John Snow, Inc./AIDSTAR-One
Daniela Ligerio	Gender Technical Working Group
Maury Mendenhall	Orphans and Vulnerable Children Technical Working Group
Lyn Messner	EnCompass LLC/AIDSTAR-One
Michele Moloney-Kitts	Together for Girls
Colette Peck	Orphans and Vulnerable Children Technical Working Group
Diana Prieto	Gender Technical Working Group
Francelina Romão	Ministry of Health, Mozambique
Mary Sawyer	Emory University School of Medicine
Derrick Sialondwe	Livingston Pediatric Centre of Excellence
Clara Sommarin	United Nations Children's Fund Child Protection Team
Valerie Tagwira	Family Support Trust Clinic, Harare Hospital, Zimbabwe/Seconded to Family Support Trust
Stephanie Weber	EnCompass LLC/AIDSTAR-One
Monique Widyono	Gender Technical Working Group
Brenda Yamba	U.S. Agency for International Development Lesotho

APPENDIX III: RESOURCES

Full presentations made by participants and additional meeting-related documents and reports can be accessed on the AIDSTAR-One website at www.aidstar-one.com/focus_areas/gender/resources/technical_consultation_materials/prc

Additional resources shared by participants before and after the meeting include:

Ajema, C., E. Rogena, H. Muchela, B. Buluma, and N. Kilonzo. 2009. *Standards Required in Maintaining the Chain of Evidence in the Context of Post Rape Care Services: Findings of a Study Conducted in Kenya*. Nairobi, Kenya: Liverpool VCT, Care & Treatment, the Division of Reproductive Health, and the Population Council.

Family Health International. 2007. *HIV Counselling and Testing for Youth: A Manual for Providers*. Research Triangle Park, North Carolina: Family Health International.

International Rescue Committee (IRC) and the United Nations Children's Fund (UNICEF). 2011. *Advancing the Field: Caring for Child Survivors of Sexual Abuse in Humanitarian Settings—A Review of Promising Practices to Improve Case Management, Psychosocial & Mental Health Interventions, and Clinical Care for Child Survivors of Sexual Abuse*. New York: IRC and UNICEF.

Keesbury, J., and J. Thompson. 2010. *A Step-by-Step Guide to Strengthening Sexual Violence Services in Public Health Facilities: Lessons and Tools from Sexual Violence Services in Africa*. Lusaka: Population Council.

Ministry of Health (Malawi). 2012. *Guidelines for Provision of Comprehensive Services for Survivors of Physical and Sexual Violence at Health Facilities in Malawi (One-Stop Centres)*. Malawi: Ministry of Health.

Ministry of Public Health and Sanitation and Ministry of Medical Services (Kenya). 2009. *National Guidelines on Management of Sexual Violence in Kenya*. Nairobi, Kenya: Ministry of Public Health and Sanitation and Ministry of Medical Services.

Population Council. 2008. *Sexual and Gender Based Violence in Africa: Literature Review*. Nairobi: Population Council.

Speight, C. G., A. Klufio, S. N. Kilonzo, C. Mbugua, E. Kuria, J. E. Bunn, and M. Taegtmeyer. 2005. Piloting Post-exposure Prophylaxis in Kenya Raises Specific Concerns for the Management of Childhood Rape. *Royal Society of Tropical Medicine and Hygiene* 100:14-18.

Stoltenborgh, M., M. van Ijzendoorn, E. Euser, and M. Bakermans-Kranenburg. 2011. A Global Perspective on Child Sexual Abuse: Meta-Analysis of Prevalence Around the World. *Child Maltreatment* 16(2):79-101.

The Teddy Bear Clinic and the Centre for AIDS Development, Research and Evaluation. 2003. *Pre and Post Test HIV Counselling for Children: Guidelines for Counsellors*. South Africa: Centre for AIDS Development, Research and Evaluation/Department of Health.

United Nations Children's Fund, U.S. Centers for Disease Control and Prevention, and Muhimbili University of Health and Allied Sciences. 2011. *Violence against Children in Tanzania: Findings from a National Survey, 2009*. Dar es Salaam: United Republic of Tanzania.

United Nations Children's Fund, World Health Organization, Family Health International, the Global Network of People Living with HIV, Johns Hopkins University, Makerere University, and Uganda Paediatrics Association. 2010. *Second Global Consultation on Service Provision for Adolescents Living with HIV: Consensus Statement*. New York: United Nations Children's Fund.

World Health Organization. 2011. *Guideline on HIV Disclosure Counselling for Children up to 12 Years of Age*. Geneva: World Health Organization.

World Health Organization, Stop Rape Now, United Nations Population Fund, and United Nations Children's Fund. 2011. *Final Report: Responding to the Psychosocial and Mental Health Needs of Sexual Violence Survivors in Conflict-Affected Settings*. Geneva: World Health Organization.

World Health Organization and United Nations Children's Fund. 2010. *Policy Requirements for HIV Testing and Counselling of Infants and Young Children in Health Facilities*. Geneva: World Health Organization.

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