

Supporting children and adolescents who have experienced sexual abuse to access services: Community health workers' experiences in Kenya

Abstract

Child sexual abuse (CSA) is a global health problem with significant health consequences. The World Health Organization recommends immediate and long-term treatment for all survivors. However, in low- and middle-income countries, less than 10% of sexually abused children seek health services. Community health workers (CHWs) can potentially increase uptake of services, but, the risks and benefits of services provided by CHWs are poorly understood.

Methods

Through in-depth interviews, we examined the experiences of CHWs providing services to children in Kenya. Sixteen CHWs were purposively selected from two locations. Data were audio-recorded, transcribed verbatim and analysed thematically.

Findings

Nearly all the CHWs reported assisting children who had experienced sexual abuse. Children were brought to their attention by caregivers, neighbours, teachers, local authorities or the police. CHWs roles included providing information and advice, assisting the child to report to the police, access healthcare or find shelter. Multiple challenges were reported including lack of support from formal institutions; community norms; safety concerns; inadequate resources and interference from family, perpetrators and local authorities. Lack of protocols and training on how to handle children was evident.

Conclusions

CHWs are a crucial community-level resource for CSA survivors and their caregivers. However, community norms, lack of guidelines and training may compromise the quality of services provided. There is a significant gap in literature on service models for CHWs

delivering CSA services. Data are lacking on what services CHWs can effectively offer, how they should be delivered and what factors may influence delivery, acceptance and uptake of services.

Key words: Child sexual abuse, Community health workers, Sexual violence services, Qualitative

1. Introduction

Child sexual abuse (CSA) is a globally recognised problem with significant health and social consequences. Globally, nearly one in four girls and one in 10 boys have experienced sexual abuse (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Stoltenborgh, Bakermans-Kranenburg, Alink, & van Ijzendoorn, 2015; Sumner et al., 2015). There are big disparities in prevalence between regions, countries and even communities within the same country. In low- and middle-income countries (LMIC), prevalence ranges from 4% to 38% (Sumner et al., 2015). Prevalence also differs by gender with girls being more likely to experience violence, for instance, in Kenya among young people aged 18-24 years, 32% of females and 18% of males report experiencing some form of sexual violence as children (UNICEF, 2012).

There are serious health consequences of CSA and these can manifest either acutely or chronically with children more likely to suffer physical injuries, anxiety, depression, substance use disorders, have risky sexual behaviour, gynaecological problems including sexually transmitted infections, unwanted pregnancy and chronic pelvic pain (Cate Fisher, Alexandra Goldsmith, Rachel Hurcombe, Claire Soares, & IICSA, 2017; Maniglio, 2009). Similarly, child survivors suffer social and emotional impacts which can be lifelong including shame, low self-esteem, unstable relationships, social disconnection and antisocial behaviour (Cate Fisher et al., 2017; MacGinley, Breckenridge, & Mowll, 2019). To mitigate these effects, the World Health Organization (WHO) advocates for timely uptake of appropriate services by all children and adolescents who experience sexual abuse (WHO, 2017). These services include post-

exposure prophylaxis for HIV which should be given within 72 hours, sexually transmitted infections prophylaxis, emergency contraception to prevent pregnancy and psychosocial support (WHO, 2017).

Despite the recommendations, it is widely reported that the majority of children and adolescents who experience sexual abuse do not access any form of services. National surveys conducted between 2007-2013 in seven LMIC countries including Kenya indicate that the majority of sexually abused children did not access any services (Sumner et al., 2015). Access to services varied markedly by country and gender with boys less likely to access care compared to girls, for instance, in Kenya, 3.2% of girls accessed services compared to only 0.4% of boys (Sumner et al., 2015). Notably, children are heavily reliant on their caregivers and other adults in the community to seek services, and, contexts where CSA is common may lack formal child social protection mechanisms and well-defined referral pathways to care.

In Kenya, the Department of Children Services (DCS) is in-charge of planning, providing, coordinating and supervising child protection services (Department of Children Services, 2019; Government of Kenya, UNICEF, & Global Affairs Canada, 2015). To implement its mandate, the department works in conjunction with other government departments and ministries, development partners such as UNICEF Kenya and non-governmental organisations. Children's officers and social workers are employed under the different institutions to carry out case management and ensure affected children receive the necessary services. In 2006, the DCS in partnership with Childline Kenya, a child welfare organisation, established a free national helpline for reporting of child protection issues including sexual abuse where anyone can call and report suspected abuse. It is the role of DCS to then investigate reported cases and act to protect the children. However, there are major challenges both in reporting and within the

institutions charged with assisting the children. These challenges include limited access to phones for children experiencing abuse; limited reach of the helpline services in some regions; lack of capacity to act on reported cases due to shortage of qualified staff; financial constraints; duplication of roles across multiple stakeholders; and, poor coordination between institutions (Government of Kenya et al., 2015; Wangamati, Sundby, Izugbara, Nyambedha, & Prince, 2019). At the community level, child abuse and protection issues are usually addressed in an ad hoc manner by religious leaders, elders and chiefs. Moreover, comprehensive referral mechanisms of survivors between the community and the formal healthcare system where timing is usually crucial are lacking and the role of linking survivors to health facilities often falls on community health workers (CHWs).

CHWs are local resource persons with the potential to act as a link to healthcare and other services for survivors of sexual violence (Gatuguta et al., 2017). Evidence shows that CHWs-delivered interventions can help improve health outcomes such as access to care, early diagnosis, adherence to treatment, retention in care, and, morbidity and mortality for marginalised and vulnerable populations (Christopher, Le May, Lewin, & Ross, 2011; Kenya et al., 2013; Tomlinson et al., 2014; WHO, 2010; Wouters E, Van Damme W, van Rensburg D, & H., 2008; Wouters, Van Damme, van Rensburg, Masquillier, & Meulemans, 2012). In Kenya, CHWs are the lowest official level of service provision within the six-tier healthcare system (Ministry of Health, 2006, 2014a). They are minimally trained, work on a voluntary basis and are supervised by a community health extension worker (CHEW) employed by the government.

The roles of the CHWs are outlined under the community health strategy and include creating awareness and promoting hygienic practices and healthy lifestyles in the community; treating

simple illnesses; improving health-seeking behaviours and implementing interventions and services closer to the community (Ministry of Health, 2006, 2014a). Sexual and gender-based violence (SGBV) falls under the health promotion and disease prevention role and CHWs are expected to raise awareness about SGBV and available services, mobilise community response to SGBV, and, refer survivors for services (Ministry of Health, 2013). Although outlined in the community health strategy as a role, there are no clear structures of how CHWs should carry out this role. For instance, there are no clear referral pathways for CSA survivors. While anecdotal evidence shows that CHWs deal with CSA in their day to day activities, there is limited documentation of their experiences or impact on care. In this study, we aimed to examine the experiences of CHWs providing services to child survivors and understand the types of support CHWs currently provide to children and adolescents who are sexually abused and explore their perceived barriers or facilitators to delivering an optimum service.

2. Methods

2.1 Design

This study was part of a larger case study designed to explore the benefits and drawbacks of using CHWs in sexual violence services that involved collecting quantitative and qualitative data from survivors, CHWs, professional healthcare providers and other stakeholders. In this paper, we report on qualitative data collected from CHWs on their experiences supporting children and adolescent survivors of sexual violence access healthcare and other services.

2.2 Location

The study was conducted in two regional referral hospitals in Kiambu and Nakuru County. The two hospitals, approximately 100km apart, were purposively selected as they both have active CHWs and they treat a high number of sexual violence survivors. The hospitals are level 4 and level 5 facilities, and, unlike lower level facilities, they are ideally able to provide the complete package of care for survivors. The services offered to survivors in both hospitals are stipulated

in the National Guidelines on Management of Sexual Violence in Kenya and include medical, psychosocial and forensic services (Ministry of Health, 2014b). CHWs attached to these hospitals serve both rural and urban communities. The urban communities are multi-ethnic while the rural communities are usually from a single ethnic community. While Kiambu County has a mainly farming rural community, Nakuru County has mainly pastoralist rural communities. These communities were selected to explore the diversity of CHWs experiences as well as the potential benefits and drawbacks of CHWs services to survivors in diverse settings.

2.3 Participants and recruitment

We aimed to interview CHWs who had been involved in providing services whether formal or informal to survivors. Although CHWs were not selected on the basis of previous contact with a survivor, the selection of the hospitals and the recruitment process was designed to maximise the likelihood of such contact. All the CHWs interviewed reported at least one encounter with a child or adolescent survivor. Although according to WHO adolescents refer to those aged 10-19 years, for purposes of this study, we refer to only those aged up to 18 years, who are all legally considered children in Kenya.

CHWs were selected purposively using different approaches in the two sites. In the hospital in Nakuru County, CHWs were recruited through a nurse counsellor who identified CHWs who had been escorting survivors to the hospital or who had taken part in other non-SGBV related hospital activities. She contacted the CHWs by phone, explained the study briefly and invited them to come and speak to the lead author. If they agreed, an appointment date was scheduled. On the appointment day, the nurse counsellor introduced the CHWs to the lead author who explained the study in detail and requested CHWs to participate. In the hospital in Kiambu County, CHWs were identified through the CHEW. The CHEW was approached by the lead

author and she in turn organised a group meeting for the lead author to meet the CHWs. During this meeting, the lead author explained the study to the CHWs and invited them to participate. The CHWs who agreed to participate then privately scheduled individual interview time with the lead author. In both facilities, all the CHWs approached agreed to participate. We included both male and female CHWs aged over 18 years working in the respective communities and could communicate in either English or Swahili. CHWs were included only if they had been engaged as a CHW for at least 3 months.

2.4 Data collection

We conducted in-depth interviews with 16 CHWs. Interviews were conducted by the lead author in English or Swahili depending on the language preferred by the CHW. The lead author is an experienced researcher who has previously conducted interviews with CHWs, healthcare professionals as well as service users. We used interview guides with open-ended questions. The interview guides were developed based on the study objectives and the existing literature; and, were reviewed by all the authors. Topics covered in the interview guides included CHWs experience of being a CHW in general, attitudes and experiences providing sexual violence services as well as linkages with formal healthcare services. All interviews were audio-recorded with permission from participants and lasted between 40-90 minutes. A private room within the hospital was used for interviews in Nakuru County while a private room in a local school was used for interviews in Kiambu County.

2.5 Data analysis

Interviews were transcribed verbatim, with interviews in Swahili first transcribed in Swahili and then translated into English. NVivo 11 software was used to manage the data and for coding. We used an inductive approach to coding: as there is limited prior data on CHWs providing services for CSA survivors to inform pre-determined codes, this approach allowed important concepts and themes to emerge from the data (David R. Thomas, 2003; Elo &

Kyngas, 2008; Hsieh & Shannon, 2005; Pope, Ziebland, & Mays, 2000). Data were analysed thematically (Braun & Clarke, 2006; Pope et al., 2000).

2.6 Ethical considerations

Ethical approval was obtained from the institutional ethics review committees of the London School of Hygiene and Tropical Medicine (Ref. 9896) and Kenyatta University (Ref. PKU/386/E32). Relevant county authorities and officers in charge of the health facilities gave permission to conduct the study.

Written informed consent was obtained from all participants prior to being interviewed. Participants either read or were read a pre-prepared study information sheet (in English and Swahili) and informed consent form before they consented. Participants were informed that they had the option to stop the interview or not answer any question/s they were not comfortable with. Anonymity and confidentiality were maintained throughout the study: consenting and interviews were conducted in a private room; codes were used in place of names; study materials were kept locked all the time with access to the lead author only; and, all digital records were encrypted and password protected.

3. Findings

3.1 Characteristics of CHWs

Sixteen CHWs, 13 females and three males, were interviewed. The mean age was 49 (range 35-66) years. The majority of the CHWs were married, most had a secondary education or above, and all had served as CHWs for more than 3 years with the longest having served for more than 14 years. The majority of CHWs were self-employed or unemployed with only one CHW reporting formal employment. The characteristics of the CHWs are summarised in table 1.

Table 1: Characteristics of all interviewed CHWs

	Characteristic	Number
Age (years)	Mean (Range)	49.2 (35-66)
Gender	Female	13 (81%)
	Male	3 (19%)
Education	Primary	4 (25%)
	Secondary	9 (56%)
	College	3 (19%)
Marital status	Single	1 (6%)
	Married	9 (56%)
	Separated/widowed	6 (38%)
Years of service	3-5 years	9 (56%)
	6-10 years	3 (19%)
	> 10 years	3 (19%)
	Duration not given	1 (6%)

3.2 CHWs' work context and roles in the community

All the CHWs were formally linked to either of the facilities through a CHEW. Although located in the hospital, the CHEWs were based in a department linked to the public health arm of the hospital which is independent of the clinical services arm where survivors were treated. Thus, there was no direct formal link between CHWs and the healthcare professionals providing services to the survivors. All CHWs reported that they played multiple roles in the community (table 2). Although CHWs were trained in some of the roles and they fell under their job description, many such as education, provision of food and finances and conflict resolution were beyond their duties.

Table 2: Reported roles of CHWs

<p>Roles of CHWs in the community</p> <ul style="list-style-type: none">• Hygiene promotion• Immunisation education• Creating awareness on HIV and HIV testing• Tracing patients who defaulted on HIV/TB treatment• Identifying very sick people in the community and linking them to care• Identifying sexual violence survivors and helping them access services• Referring and accompanying sick patients to hospitals• Providing different forms of counselling• Mediation between disagreeing parties particularly couples• Attending to gender violence including providing advice, accessing services and reconciliation.• Supporting community members with food and finances• Advising on education, scholarships and financial aid
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3.3 CHWs experiences with CSA

Interviews revealed that CHWs were in constant contact with survivors of sexual violence in their community during their routine roles. Although they did not assist all the survivors, they were confident that they knew about most of the cases happening in their community. While they assisted both adults and children, children constituted the majority of survivors and cases of CSA were more likely to be brought to their attention versus sexual violence against adults. Nearly all the CSA cases brought to their attention were by known perpetrators in the same community including relatives, neighbours, teachers, religious leaders and other children. In spite of the CHWs being from different facilities and having a few notable differences in their characteristics (all the CHWs in Nakuru county were female, more CHWs from Nakuru had a secondary education and above compared to Kiambu and were generally younger), their reported experiences with CSA were largely similar across the sites. Few male CHWs were interviewed and the data collected were limited to make any informed comparisons between the experiences of male CHWs versus those of female CHWs in dealing with CSA.

Our analysis of data identified four main themes on CHWs experiences with CSA. These themes revolved around acceptance of CHWs services for CSA survivors; the services CHWs

offered to these survivors and their caregivers; the challenges they faced while offering these services; and gendered expectations in CSA prevention and response.

3.4 Community acceptance of CHWs services for CSA survivors

All the CHWs had heard of a case of child sexual abuse in their community. Nearly all had assisted at least one child access services. CHWs reported that members of the community recognised them as resource persons for sexual violence assistance and therefore referred abused children to them. In a few instances, CHWs were informed of cases while carrying out their duties, however, in most instances, members of the community actively sought out the CHWs to report the cases. Community members reported to CHWs via mobile phones or visiting CHWs at their home or workplace. CHWs mentioned different people from the community who informed them of CSA indicating a wide acceptance of their services. These included family members (especially mothers), neighbours, members of the general community and local authorities.

“For the children mostly, their neighbours do know (meaning the neighbours usually have knowledge of abuse). When the neighbours know, they begin interrogating the child and if it is true they look for me. They ask me how we are going to help these children.”

TC02

Teachers were also reported as frequently referring children to CHWs. The teachers either had children reporting abuse to them or noticed abnormal behavior in children while at school. The teachers would then request CHWs to come talk to the children. Although a few CHWs reported providing SGBV sensitisation in schools to either teachers or students, there were no protocols on referral from teachers to CHWs. Those teachers who contacted CHWs did so on the basis of previous interactions with the CHW or knowledge of their work in the community.

“These children are in school, they are so open to their teachers, and once the teacher is around, they know us (CHWs), they know the work I do. So, the teacher observed that

the child had some abnormalities and then she called me and told me about the child. So, I tried to talk to the child and then she opened up.” NC06

There was also evidence that CHWs were recognised by some formal authorities as referral links for CSA to health facilities. CHWs reported cases where they were called by police to accompany abused children to the hospital. These were often children whose caregivers decided to report to the police before taking the child to the hospital. One CHW also reported being contacted by the national helpline on a specific case.

CHWs observed that the community members reported to them for various reasons, among them, their accessibility. As the CHWs worked within the community often visiting households or organising health-related events, community members knew them and their work which made it easy for them to approach them. Because CHWs lived in their neighbourhood, community members could approach them for help at any time, including at night.

Trust and ability to maintain confidentiality were also cited as enabling community members to disclose CSA to CHWs. Community members who knew about cases of CSA and were afraid of being involved themselves would report the cases to CHWs because they knew the CHW would keep the information given to them confidential.

“We noted that this child is being used by that man (meaning sexually abused). (Interviewer: How did you note?) Someone came and told me. You know as a community volunteer, when people learn that you can keep secrets, they tell you things. And if you are friendly with them, they will be open with you. So, someone came and told me and asked me to investigate and asked me not to say that they told me.” TC04

CHWs reported that a wide variety of CSA cases were reported to them. According to the CHWs, there was a tendency for the cases to be of younger children with few older adolescents

(15 years and above) mentioned. CHWs reported that they often assisted children living in complex family situations. Children where either one or both parents were reported to be alcoholics were particularly vulnerable, as were children from very poor families; children whose mothers were unemployed, were poorly paid or worked away from home; and, families where the mother was deceased, or parents were separated. The reporting of vulnerabilities suggests that children whose mothers were socially disadvantaged or absent were at a higher risk. This may reflect gendered attitudes towards CSA and child protection roles that exist within the community. Some of the CHWs also reported that cases of disabled children being sexually abused was common.

3.5 Services provided by CHWS to children

CHWs provided a wide range of services to children which were both health-related and non-health related. For CSA cases, services included advising caregivers and children, accompanying them to hospitals, police and safe houses. They also provided sensitisation on sexual violence through community outreach as well as specific sensitisation sessions in schools and specific community groups.

3.5.1 Advice and accompaniment

CHWs provided advice on what to do when a child was abused and linked children to healthcare. Many CHWs mentioned that they personally escorted abused children to the hospital and ensured they received treatment. This was particularly important as community members lacked information about the services available.

“On the side of defilement, I don’t refer. I take myself step by step because you know some people they don’t know when you are coming for such a case you are not supposed to pay anything. Even if you are filling the P3 (police record form), you are not supposed to pay anything, you are not supposed to que the line (in the hospital waiting for services), so I direct the people from my area.” NC01

In addition to advising on seeking treatment and escorting children to hospitals, CHWs also advocated for children in the event there were barriers to children receiving services, explaining

to community members why it was important to seek treatment. Advocacy was particularly essential in cases where children's treatment was overlooked once parents negotiated with perpetrators and received compensation as this CHW explains:

"I just go back to the family and I confront them (after hearing about the negotiations and settlement), and I tell them this is bad because you see now, you are grownups, but we have a kid here and there is this girls' future. You see now being a parent you have been given 20 thousand shillings (approximately £150), and the girl has a problem that will affect her for the rest of her life." NC02

3.5.2 Sensitisation and awareness raising on sexual violence

In addition to responding to violence, CHWs were also involved in prevention through sexual violence awareness creation in the community. This they did through community outreach, sensitisation in organised groups such as churches and schools. CHWs explained that because their work was known locally, they were often invited to group meetings to speak. They also approached group leaders such as church leaders and requested to be allowed to teach in the congregation. They also taught individual community members on what to look for in children that might alert them to CSA as well as how to talk to their children about violence. School-based teaching was provided to both teachers and students.

"There is something that we normally do to the churches, let me say on my part, because when we have the women conference, the women fellowship, we try to train them if the girl or the boy has something, these are the symptoms. So, when they see these symptoms they look for you: ' when my child sees the father, they run away, or when they see any other man.' So, from there we investigate, or the child has withdrawn from play or things they used to do, so we try to train the mothers and even the fathers, that's why they report to us" NC02

Notably, although CHWs provided sensitisation and awareness raising in the community, there was no evidence of a standardised structure of how it was organised or delivered. CHWs reported different activities undertaken at each CHWs' discretion.

3.6. Challenges Handling CSA

Multiple challenges in the course of their work were reported. Although most CHWs felt it was their duty to provide these services and derived satisfaction from doing this, they reported they were often under-equipped to provide these services. For instance, they lacked the requisite knowledge and skills, there were no clear referral pathways and some contextual factors made successful referral and treatment of survivors difficult. The challenges mentioned related to socio-economic standards, health system structure, community norms and attitudes, as well as lack of adequate training.

3.6.1 Knowledge, skills and attitudes towards sexual abuse

There were different levels of knowledge manifested by the CHWs with regards to how to deal with CSA. This meant that the responses were not standardised with some CHWs prioritising medical attention while others prioritised the legal and justice issues. For instance, some CHWs felt that CSA survivors should first report to the police before going to the health facility despite the fact that reporting to the police is not a pre-requisite to treatment in Kenya. The level and type of knowledge displayed may reflect the limited and diverse training reported by all the CHWs. Few CHWs reported having received any training on GBV and none reported being trained on dealing with CSA. Many pointed out that lack of training was a real drawback to their ability to assist children and their caregivers. Among those trained, training varied as it was provided by different NGOs. For instance, one CHW reported attending a meeting while another reported attending a course where they were issued certificates. The actual content and duration of training could not be established. Some CHWs felt that the training provided was not planned or designed for them as the following comment illustrates.

“The way we were trained, we do not feel the training was helpful because they even told us the training was not meant for us, they hijacked the training (meaning the CHWs attended a training meant for a different cadre of workers and therefore not tailored to their needs)” TC01

Although some as illustrated by the CHW above did not feel the training provided was helpful, others observed that even though the training received was not comprehensive, it was very beneficial. One CHW reported a significant difference in how she handled survivors of CSA before training and after she received training saying:

“I remember there was a case and I was not trained, so what I did because I was not trained, I washed the girl and I brought the girl to the hospital because I did not have any information. But after training now, there was an incident where I talked to the parent if it is abcd, the defilement has been done, don’t wash the girl let us go to the hospital and we had the information it was very good, and she was helped.” NC02

This not only highlights that the CHWs are aware of the need for and are keen to receive training, but also demonstrates the importance of training and the difference it can make in the management of child survivors.

Different interpretation of what constitutes violence was evident, with some CHWs considering abuse in the same light as less contextually accepted forms of sexual activity.

“As I can classify it (sexual violence), it can be raping, sodomising, lesbianism and this one called gays. [...] This other one, lesbianism that one comes with pornography. And it’s still a threat and there is another thing in secondary school they call it vibrator, have you ever heard of it? Of course, there is that thing, and peer pressure also pulls somebody to that game. So, we need to educate our youth, and prepare them for their sex behavior and character, so we have to be given tools to educate them as we are at the grassroots and to eliminate that one.” TC08

This lack of clear distinction of what constitutes violence may indicate that CHWs being from the communities they serve may share some common community attitudes towards sexual abuse. These attitudes may therefore shape how they respond to violence and survivors of abuse. It also demonstrates an area where those involved in the training of CHWs could target to ensure that services provided to survivors are sensitive and appropriate.

3.6.2 Knowledge and attitude towards CSA in the community

Lack of awareness about sexual violence among community members was highlighted as a hindrance for CSA prevention and treatment. Although CSA was common, there was a general lack of understanding among community members, (with CHWs emphasising that mothers especially lacked knowledge), about what to do to protect their children and the importance of seeking care when a child was abused. CHWs perceived that this led to many children being abused and not being treated. Furthermore, the common practice of compensating parents once a child was abused to persuade them not to report hindered treatment.

“They (community members) are ignorant, they ought to be educated to remove the ignorance. They value money more than the human body, when a mother is given money after her child is raped, she keeps quiet.” TC07

3.6.3 Security and safety concerns: fear of retaliation

CHWs observed that once a case of CSA became known, handling it was not only a sensitive issue but could also be accompanied by threat of harm. This was especially so in incestuous cases where families wanted to avoid embarrassment. In some cases, relatives reporting CSA, especially mothers, were threatened against reporting by other members of the family. Additionally, in cases where the perpetrator was the breadwinner, relatives were reluctant to report. One CHW explained that with the recently implemented sexual violence laws, the prison terms and fines for perpetrators were severe and relatives were often reluctant to have a perpetrator put in prison for such a long time. In such instances, the CSA was often kept secret and the child was not treated. Where CHWs became aware and intervened, they felt threatened by the relatives. In some instances, the threat was quite real as one CHW reported being physically assaulted when they intervened in a case of severe physical abuse.

Fear of being physically harmed was also manifested with other perpetrators beyond relatives. CHWs observed that the other common perpetrators were known criminals who could easily attack them particularly because security was generally poor in the community. Once the

identity of a CHW who was assisting a survivor was known, they could be targeted even in their own home with the possibility of not only physical injury but also possible loss of life.

“These people who do this (perpetrators), they are also the thugs of the area. Our houses here, [...] it is just iron sheets and timber here and there, another one here, just a sketch of a house (meaning they are not safe). So, if somebody wants to come here by force, he will just pluck out the iron sheets, and you get the person inside. So, we don’t want to do it directly (assist abused children to report). We are afraid. Because we have seen many cases whereby somebody loses his or her life because of community work.” TC09

3.6.4 Lack of formal support

The majority of CHWs expressed dissatisfaction with the level of support they received while dealing with cases of CSA from local authorities, the police and health facilities. The lack of support was demotivating and CHWs felt they could not deliver services effectively due to the lack of support. For instance, many of the CHWs reported that they did not feel they could report cases of CSA to the police as they did not trust them. They observed that some police officers colluded with perpetrators thus revealing the identity of those assisting the survivor to perpetrators and, therefore putting those who report cases in danger. In some cases, compromised police were known to actually threaten CHWs who were supporting survivors thus raising more security concerns for CHWs. Even in instances where the police did not necessarily collude with perpetrators, there was a lack of enthusiasm to assist survivors as well as failure to prosecute perpetrators once they were reported.

“So, when we found the police, the police were like, “the mother to this child... this child has been brought here many times, we are used to this” (meaning the child has been abused multiple times because the mother is presumably negligent). I told them the important issue is not getting used to the parent, but how do you handle this case. So, you see because of being harassed and the threats (from police) I told this man, let us take this child to the hospital, so we went.” TC04

The police response described not only demonstrates a failure to carry out their role, but also some aspect of victim blaming. As TC04, reports, the police failed to act because they felt the

mother of the child was neglecting the child thus leading to multiple episodes of abuse. This further highlights the gendered expectations within the community. Moreover, the fact that the police report that they had knowledge that the child had been abused on multiple occasions also demonstrates the failure of the system to protect vulnerable children. Although the majority of CHWs held the view the police were not helpful, these were contrary to the experience of a few CHWs who reported good working relations with the police. As already mentioned some police officers even contacted CHWs when they had cases of CSA.

CHWs further reported that once they took children to the hospital, the services were slow, and they had to queue for many hours while waiting for services. This lack of referral and linkage mechanisms between the CHWs and health facilities was highlighted by many of the CHWs as a barrier to their work. They observed that because healthcare workers did not recognise them, they could not write referral notes and send the survivor to the hospital and once they accompanied the survivor to the hospital, they could not guarantee prompt services. Given that their work was voluntary, and they attended to many clients, staying for long periods with the survivor at the hospital was undesirable.

“I do not know, it is like they (healthcare workers) view CHWs as rubbish, I do not know. Even if you are escorting a patient, in fact when you escort a patient, they make you wait for very long.” TC07

However, a few CHWs reported different experiences with the hospital as they personally knew specific nurses they approached directly when they escorted survivors to the hospital and received immediate attention. They also mentioned sending survivors with a note when they could not physically escort them. This note was not a formal referral note and it was not clear how the case was handled once the survivor was in the hospital.

3.6.5 Limited resources

Although services were free in most facilities, survivors often could not raise funds needed for transport to the hospital. As CHWs observed, most of the survivors were financially needy. Hence, the CHWs either paid for the fare or organised community funds drive to raise the money but these did not always yield the required amount. As CHWs worked on a voluntary basis and hardly received any compensation, the need to support survivors to get to the hospital was burdensome.

“Even if I use a motorbike (motorbike taxi for transport to hospital) I use my own pocket, unless I get a parent who is able, at the end of the day they refund but they are very rare. Because these cases happen to the poor people, I don’t know why. I don’t know if it is poverty or lack of security, I don’t know because the cases which I’ve dealt with, they are the people who are vulnerable and poor.”NC01

Moreover, all the CHWs except one were either self-employed in small informal businesses or unemployed. This was reported as both a challenge and facilitator for service provision. Having a business within the community meant that most CHWs had regular contact with community members while carrying out their normal businesses. As CHWs are not allocated offices, it also meant that community members knew where to access them easily when needed and many of the CHWs reported that cases of CSA were brought to their attention at their business premises. However, the lack of a regular income also meant they had limited time to allocate to assisting survivors.

3.7 Gendered expectations in CSA prevention and response

There was strong evidence of gendered expectations towards abuse prevention, response and reporting as some findings above have alluded. Many CHWs responses indicated that women were expected to protect their children from abuse and were often blamed of neglect if their children were abused. Women were also expected to ensure the children received treatment if abused. CHWs also mentioned providing advice and training to women and women’s groups to help them improve their knowledge on prevention and response to CSA. Few CHWs mentioned any men’s responsibilities in abuse prevention, response or not perpetrating abuse.

The gendered attitudes within the community were also evident in some of the CHWs interviewed in their views on survivors and the advice they provided.

“You can help them (survivors) because there is another woman here who was raped while she was drunk. Such a person I will tell them that taking alcohol as a woman or girl is not right. You will find that here you can be raped because you are not even helping yourself. You can scream for help but when you are drunk, you cannot. You tell them that alcohol is not good. And don’t go near men when they are doing their own things even if they are practicing karate because that is where thoughts of rape come up. You have to know how you will live. You need to know whom you will hang around with. Because even a kikuyu saying says that when you associate with a bad person then you will end up doing bad too. For example, getting back home at nine o’clock in the night and you have parents who are warning you about your behaviour. Those are acts (meaning rape) that you could have caused them yourself.” TC03

This further illustrates that CHWs may share the normative attitudes within the community and this may not only influence the type of advice provided but may also lead to victim blaming and further victimisation. Although very few male CHWs were interviewed, in general, it was notable that the male CHWs were less likely to report ever assisting sexual violence survivors (whether adults or children); more likely to report reluctance to get involved with survivors; and, to portray higher levels of misinformation about sexual violence and attitudes condoning of victim blaming. These observations need further investigation on a bigger sample of CHWs.

4.0 Discussion

To our knowledge, this is the first study that has explored CHWs’ experiences supporting children and adolescents who have been sexually abused. Our study has established that CHWs frequently interact with children who are sexually abused and their caregivers. They play various roles including giving advice, accompanying survivors for services and creating awareness in the community. They are however faced with multiple challenges such as lack of formal support, limited resources, security risks and, attitudes and social norms that hinder

services. Moreover, there are no protocols and guidelines for CHWs dealing with CSA, and, their training on CSA is limited or non-existent.

Our study indicates that CHWs are already involved in local responses to CSA and influence decisions made regarding the children's care. This is consistent with findings of a systematic review on CHWs services to sexual violence survivors (Gatuguta et al., 2017). Although they are a crucial link between the community and services, there are indications that because CHWs come from the communities they serve, they may share the normative attitudes and practices towards sexual violence in the community. Negative socio-cultural norms and stigma may reinforce abuse of children, hinder disclosure and care-seeking (Muzdalifat Abeid, Projectine Muganyizi, Pia Olsson, Elisabeth Darj, & Axemo, 2014; WHO, 2009).

While CHWs have the potential to influence norms and responses to CSA, sharing these norms might make it difficult for them to respond to sexual violence cases in an empathetic manner and in accordance with recommended guidelines. In our study, we found that although CHWs are doing their best to respond to what they perceive as a real need, with limited resources and training, they may be inadvertently condoning violence, have gendered expectations about prevention and response, and in some cases, blame victims for experiencing violence. Research shows that training of CHWs may improve their effectiveness in service delivery (Marwa Abdel-All, Barbara Putica, Deversetty Praveen, Seye Abimbola, & Joshi, 2017). Similarly, although evidence is limited among CHWs, training of healthcare workers may improve cultural competence and lead to change in attitudes therefore reducing stigma associated with various health conditions (Geibel et al., 2017; Linda Govere & Govere, 2016; Nyblade, Stangl, Weiss, & Ashburn, 2009). Our study found that very few CHWs are trained on SGBV and the training is not standardised. It therefore highlights an urgent need to identify the training needs

of CHWs dealing with CSA survivors and provide the relevant training to improve the quality of care provided.

Moreover, although the sample was very small, we observed that there may be differences in attitudes and response towards sexual violence between males and females: with males being more likely to be less informed, possess inadequate knowledge about sexual violence and hold victim-blaming attitudes. There was also evidence of misunderstanding between sexuality and sexual violence. These areas need further research to explore how gender might influence the type and quality of services provided by CHWs. Additionally, individual CHW characteristics such as gender may influence the respect and trust accorded to CHWs and thus acceptability of their services (Steege et al., 2018).

CHWs self-reported being trusted by community members for their ability to keep confidentiality, however, this evidence should be viewed with caution as CHWs may overstate the community's positive response in order to portray themselves more positively as is common in self-report (John Garcia & Gustavson, 1997; L Fadnes, A Taube, & Tylleskär, 2008). Given the sensitivity of CSA, more research is required to explore the acceptability of CHWs services to CSA survivors and their caregivers. CHWs services have great potential because of their close links to the community, however, studies to understand how CHWs could be better utilised to: identify hidden CSA cases and link them to care; address the socio-cultural norms that perpetuate abuse of children; and, reduce stigma of CSA are needed. Although CHWs services are potentially beneficial, our findings suggest that CHWs' attitudes may lead to revictimisation of survivors. It is therefore imperative to consider and investigate the impact of their role on children and their families to avoid further harm to survivors.

Consistent with other studies, our study identified other challenges facing CHWs when delivering services including limited resources, limited formal support, security issues, and multiplicity of tasks (Glenton et al., 2013; Kok et al., 2015; Sarin & Lunsford, 2017; Sharma, Webster, & Bhattacharyya, 2014; WHO, 2010). Particularly worth highlighting is the lack of well-coordinated mechanisms of linkage between the community, the hospital and other services. These are especially important for children as the involvement of multiple stakeholders (caregivers, teachers, neighbours and the local administrators) if not managed well, could result in delays in seeking healthcare, missing treatment completely and secondary revictimisation of children. Currently, no protocols or guidelines exist for CHWs assisting CSA survivors and referral pathways are unclear. The Ministry of Health has recently published the National Standard Operating Procedures for Management of Sexual Violence Cases in Children (MOH 2018). These guidelines however focus on children who have presented at the hospital and provide no guidelines on management or referral of children outside the health facility. Clear referral and linkage protocols and pathways for CSA survivors that CHWs can follow would make supporting children to access services more effective. More generally, comprehensive steps to address the workload (including clear definition of roles in CSA) and financial constraints faced by both CHWs and CSA survivors are critical.

Safety and security were also a major concern for CHWs with reported threat of harm from perpetrators, family members and occasionally from local authorities. There is limited data on the nature, scope and impact of violence directed towards CHWs as a result of their work. A few studies indicate that perceived insecurity may lead to poor motivation and resigning among CHWs, but these studies relate to general insecurity, rather than violence specifically directed towards CHWs because of their work (Glenton et al., 2013; Kok et al., 2015). Despite limited data on CHWs, multiple studies have shown that violence against healthcare workers is

common globally, and, has a negative impact on their psychological and physical health; leads to a huge financial burden both to individuals and the health system; and can lower their job motivation leading to poor quality of care or abandoning work altogether (ILO/ICN/WHO/PSI Joint Programme on Workplace Violence in the Health Sector, 2002; Lanctôt & Guay, 2014; Speroni, Fitch, Dawson, Dugan, & Atherton, 2014; Taylor & Rew, 2011). However, most of these studies are health facility-based and although there are likely parallels with CHWs, factors found to predict violence in health facility settings and response strategies (Al-Turki, Afify, & AlAteeq, 2016; Gillespie, Pekar, Byczkowski, & Fisher, 2016; Gordon Lee Gillespie, Donna M. Gates, Margaret Miller, & Howard, 2010; Speroni et al., 2014), may not translate easily into community settings. Thus, more research is needed in this area. In our study, there was no evidence of any safety programs, training or reporting systems for CHWs who may experience violence due to their work, and these are crucially important.

Our study had several limitations. Firstly, the data presented here represents the views from CHWs only. We did not interview children/adolescents or their caregivers regarding their experiences and attitudes towards CHWs, which may differ from those expressed by CHWs. Similarly, although we collected data from other stakeholders such as professional healthcare workers, except to mention that CHWs referred and accompanied child survivors to hospital, no specific data on their views on CHWs experiences with children were collected. While the CHWs presented a very positive view of their services and indicate that they are easily accepted in the community, studies have shown that acceptability of CHWs is not universal and may be limited due to perceived threat to confidentiality, gender norms and lack of professionalism (Glenton et al., 2013; Grant et al., 2017; Rachlis et al., 2016). Interviewing children and adolescents themselves, as well as their caregivers, is a vital next step.

Secondly, the study was designed to explore CHWs experiences with sexual violence survivors in general and was not specific to CSA. Therefore, most of the data on children arose organically during interviews, and, was supplemented by further probing when it did arise, rather than using pre-determined questions on children. The fact that there was so much data obtained this way indicates that this is a genuine area of concern that CHWs grapple with constantly. It is however possible that more insight into this area could have been obtained had more concepts and themes specific to children been explored.

Thirdly, our study was conducted in two regional facilities in urban areas and the experiences of the CHWs interviewed may differ from those of their counterparts in lower level facilities and rural areas. In particular, being level 4 and level 5 facilities means the facilities are able to offer a complete package of care for CSA survivors while lower level facilities may need to refer the child. Additionally, assistance provided by a local NGO to both facilities as well as the prior involvement of CHWs in sexual violence interventions and research may have influenced their experiences with CSA survivors particularly with regards to their response and linkages to care. Thus, there is need to explore CHWs' services to sexually abused children in broader contexts, particularly in rural areas where there are likely more hidden cases and services may be more limited.

Finally, the data collection and analysis were principally done by the lead author. The lead author is a medical doctor from Kenya and although she has not worked in the two health facilities as a healthcare provider, she has previously carried out research on sexual violence survivors in both facilities. This prior association, the knowledge of the Kenyan health system and having background knowledge of the context in which CSA occurs and the CHWs roles may have influenced her data collection, interpretation and conclusions. Critical self-reflection

was observed throughout and co-authors provided input on interview guide, themes and analysis. Additionally, although her position as a medical doctor was not disclosed to participants at the outset, when directly asked and on some occasions during the interview, it did come out and this may have influenced the information provided by the CHWs. To encourage CHWs to speak freely, she emphasised confidentiality and the fact that she was an independent researcher who was not linked to the facility in any way.

4.2 Conclusions

CHWs form a crucial bridge between the formal care systems and CSA survivors. However, the interface upon which they work is complicated as the CHWs are stuck between unclear and unsupportive health system, child protection system, police and NGOs on one hand, and communities and their beliefs, norms and expectations around violence on the other hand. This makes it challenging for CHWs to deliver services effectively and efficiently. Additionally, normative and gendered attitudes towards sexual violence, and, misunderstanding of sexuality and sexual violence among CHWS was evident and could potentially influence quality of services offered. There is a significant gap in literature on service models for CHWs delivering services to children who have experienced sexual abuse. In particular, data are lacking on what services CHWs can effectively offer, how these services should be delivered and what factors (CHWs'-related, survivor-related, structural or socio-cultural) may influence services delivery, acceptance of services and uptake. Although previous studies have found that various contextual factors can influence CHWs' performance, specific data on CSA and sexual violence in general are lacking. Understanding such factors is crucial as having interventions that are local and contextually sensitive will enhance identification of hidden cases as well as facilitate better linkage to care.

Evidently, there is need to streamline the referral and linkage mechanism between the community level, healthcare and other services. Development of standardised referral protocols and networks would enhance access to timely, appropriate and child-centred care. Similarly, security and safety concerns should be addressed, both for the CSA survivors and the CHWs. Better linkages with child protection services and availability of safe shelters for children who are at risk of revictimisation should be established. Better mechanisms for CHWs to work in conjunction with the local administration and the police would enhance security for both the children and the CHWs. Ultimately, successful CHWs' interventions will need to be accompanied by larger more concerted efforts to implement contextually relevant programmes for changing attitudes and social norms towards sexual violence in the community.

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