Knowledge hub
-
Collection of best practices

Summary of the best practice

1. Title of the best practice (e.g. name of policy, programme, project, etc.) *

Asking and Telling: Screening for Sexual Violence Against Children in School Contexts

2. Country or countries where the practice is implemented *

Kenya

3. Please select the **most relevant** Action Track(s) the best practice applies to *

- [x] Action Track 1. Inclusive, equitable, safe, and healthy schools
- [ ] Action Track 2. Learning and skills for life, work, and sustainable development
- [ ] Action Track 3. Teachers, teaching and the teaching profession
- [ ] Action Track 4. Digital learning and transformation
- [ ] Action Track 5. Financing of education

4. Implementation lead/partner organization(s) *

The Population Council and the Gender-Based Violence Recovery Center, Kenyatta National Hospital

5. Key words (5-15 words): Please add key descriptive words around aims, modalities, target groups etc. *

The project aims to identify child survivors of violence through the use of a child-friendly screening tool, coupled with a screening process that involved pupils, parents, and school personnel. The tool is administered by trained psychosocial support professionals in schools and identified survivors receive school-based counseling and accompanied referrals for comprehensive care, where necessary.

6. What makes it a best practice? *

The fact that an evaluation of the practice demonstrated strong results, not just with regard to identifying school-going large proportions of children that were experiencing sexual violence at school, around school, and at home, and connecting them to care at high rates, but also that the results also showed a ripple effect of this school-based intervention on children's home environments and wider communities, with parents and community members being catalyzed to come together and try to stamp out sexual violence against children in their communites (an unexpected result). Approaches to rolling out the intervention at low cost were identified by the community, and the intervention was taken up by UNHCR Rwanda for scale-up across that country's refugee camps with anticipated funding from UNFPA. This process was interrupted by COVID-19. The intervention was also tested with very similar results in health facility settings. Lastly, the intervention was rated as a promising practice by both a recent reivew of the Coalition for Good Schools, and a recent UNHCR review of humanitarian interventions, and was noted in the former as contributing toward safe environments for, and wellbeing of, learners.

Description of the best practice

7. Introduction (350-400 words)
   This section should ideally provide the context of, and justification for, the practice and address the following issues:
   i) Which population was affected?
   ii) What was the problem that needed to be addressed?
   iii) Which approach was taken and what objectives were achieved? *

Nationally representative surveys in the East African region show that children often experience sexual violence for the first time in school. This practice aimed to use a child-friendly screening tool to proactively identify child survivors of sexual violence (SV) in Kenyan primary school and health facility settings and connect them to care.

The screening tool was administered to 456 girls and boys in Standards 6-8 in two primary schools (and to 40 boys and girls and ages 11-17 in one hospital site). The screening process was complemented by multi-level dialogue with parents, school personnel, and community members to de-stigmatize disclosure of sexual violence.

As a result of the practice, an unprecedented proportion of children disclosed sexual violence and received care, since referral barriers were removed through the provision of school-based counseling, and accompanied referrals for acute cases. The practice proved to be feasible to implement, acceptable to children, parents, schools, and community stakeholders, and effective for enhancing the access of sexually abused children to care. An unanticipated result was that the practice caused a ripple effect within children's wider communities, leading to the prevention of further sexual violence to a certain extent.

8. Implementation (350-450 words)
   Please describe the implementation modalities or processes, where possible in relation to:
   i) What are the main activities carried out?
   ii) When and where the activities were carried out (including the start date and whether it is ongoing)?
   iii) Who were the key implementation actors and collaborators? (civil society organizations, private sector, foundations, coalitions, networks etc.)?
   iv) What were the resources needed (budget and sources) for the implementation?
   *

Parent Dialogues (January Through April 2017)
Dialogues were considered critical for gaining parents' buy-in for having their children screened and connected to services, in their absence, for an issue as sensitive as SV. Two dialogues with parents were held at each primary school. Parents of all students in Classes 6 to 8 (typically 12 to 14 years of age) were invited by the schools to participate in the one-day dialogues, which involved guided, interactive exercises conducted by the Population Council and Kenyatta National Hospital (KNH) to stimulate discussion around sexual violence against children (SVAC) and other related topics in these communities, such as the negative consequences of such abuse, barriers to child reporting, parental barriers to seeking care for affected children, and school-based screening as a possible solution.
Student Sensitization (January 2017)
Primary school students were provided information about the planned intervention by GBVRC psychologists during routine weekly student assemblies, over the course of four weeks. During the assemblies, GBVRC psychologists defined sexual abuse and informed students that their schools were taking measures to make it easier for students to receive care if or when such abuse occurred, in addition to providing details of services that would be available at the schools.
Provider Training (January 2017)
Health care providers involved in the study included four GBVRC psychologists assigned to the schools (two per school), and all available GBVRC psychosocial support staff. These providers received three days of training in narrative therapy for child survivors and their parents or caregivers, drawing on the 'Tree of Life' psycho-social support tool, and led by the Regional Psychosocial Support Initiative. Psychologists involved in screening received an additional one-day training focused on using the screening tool with children.
Screening and Service Provision (January to April 2017)
Psychologists based at the schools conducted the screening exercise during recess, free periods, and after-school activities. All students in Classes 6 to 8 with parental permission were invited to participate in the screening exercise. Children disclosing SV were asked if they would like to talk to someone further and get help, along with their parent or caregiver. Those willing received school-based counseling by the screening psychologist and/or an accompanied referral to the GBVRC.
Resources
Resources were needed to provide lunch to parents during the one-day dialogues. The other key resource was the partnership between the schools and hospital, which led to free space for the project to have screening carried out privately. Psychologists were seconded from KNH, which already prioritized partnering with communities and schools, making this a low-cost intervention.

9. Results – outputs and outcomes (250-350 words)
   To the extent possible, please reply to the questions below:
   i) How was the practice identified as transformative? (e.g., impact on policies, impact on management processes, impact on delivery arrangements or education monitoring, impact on teachers, learners and beneficiary communities etc.);
   ii) What were the concrete results achieved with regard to outputs and outcomes?
   iii) Has an assessment of the practice been carried out? If yes, what were the results? *

   The practice was identified as transformative due to its impact on learners, their parents, school personnel (head teachers and teachers) and beneficiary communities. The multi-level dialogue that accompanied the screening process enhanced parent-child communication around a previously tabooed topic. This helped parents transform into champions for their children's safety, and this sparked community action outside the confines of the school (an unintended, but very welcome, consequence). Importantly, children's voices documented during this intervention are very clear on their satisfaction with the intervention and the ways in which it transformed their school and home lives. The same can be said for parents and school personnel.

   Concrete results achieved can be summarized as social norm change within communities who were supported in not only breaking the silence around sexual violence against children, but empowered with information on free services available for child survivors, and practical support with getting help for such children. In a nutshell: 81% of parents gave permission for their children to be confidentially screened for SVAC in school, and to receive counseling and/or an accompanied referral for services, if necessary; 95% of children whose parents gave permission for them to be screened, gave their assent for screening as well; 49% of children screened reported ever experiencing some form of sexual violence; of those that disclosed, 75% received care. The achieved outcomes were thus related to enhanced willingness among parents and children to engage with a tabooed subject, enhanced disclosure among children, and expanded access to care for child survivors in school. In turn, the multi-level dialogue combined with the screening led to an outcome of safer school and home environments for school-going children, and a better sense of wellbeing while in school.

   An assessment of the practice has been carried out. The results are available here (https://knowledgecommons.popcouncil.org/departments_sbsr-rh/1251/) and here (https://knowledgecommons.popcouncil.org/departments_sbsr-rh/1597/). A recent review assessed it further, here: https://coalitionforgoodschools.org/wp-content/uploads/2022/02/Coalition_for_Good_Scools_Evidence_Review_R6.pdf.

10. Lessons learnt (300 words)
    To the extent possible, please reply to the following questions:
    i) What were the key triggers for transformation?
    ii) What worked really well – what facilitated this?
    iii) What did not work – why did it not work? *

    1) The key triggers were multi-level dialogue that focused not just on school going (through the screening and counseling processes and school assemblies), but also on key stakeholders in their lives (parents, school personnel, community leaders). This became a shared community conversation that turned what was designed to be a response intervention into something much more, leading to community-led prevention practices, as well. Another trigger involved having psychologists/trauma counselors based right at the schools. This helped promote disclosure over time, as children began to regard the psychologists as part of the school, and would stop by to talk about whatever they wanted, which often led to disclosure. The parent dialogues combined with screening and counseling also helped improve parent-child communication greatly.

    2) The parent dialogues and screening process worked really well. The dialogues were well-planned; they were interactive and used different conversation starters (e.g., skits acted out by the school children on sexual violence (put together by drama teachers and the children themselves) and other interactive exercises to break the ice and get lively conversations going. The parents also really appreciated that their questions about sexual violence, related health concerns, and available services were answered by KNH staff who facilitated the dialogues. Having the psychologist at the school, again, was really helpful, and is responsible for the high service uptake rate - counseling services were right there at the school, and this removed barriers to referral uptake. Parents of child survivors were also able to obtain counseling services at the schools, as they were often traumatized to learn that their children had experienced sexual violence.

    3) At first, the parent dialogues attracted mothers almost exclusively. When we realized this, we carried out additional dialogues for fathers only, targeting them by referring to the dialogues as a 'goat-eating' fathers-only day. This caused fathers to participate in droves.

11. Conclusions (250 words)
    Please describe why may this intervention be considered a “best practice”. What recommendations can be made for those intending to adopt the documented “best practice” or how can it help people working on the same issue(s)? *

    This intervention may be considered as a best practice because of its feasibility, acceptability, and effectiveness, as well as its low cost. It is easily adaptable, provided strong partnerships can be forged between schools and health facilities.

12. Further reading

    Please provide a list and URLs of key reference documents for additional information on the “best practice” for those who may be interested in knowing how the results benefited the beneficiary group/s. *

    Evaluation report: https://knowledgecommons.popcouncil.org/departments_sbsr-rh/1251/
    Peer-review journal article: https://knowledgecommons.popcouncil.org/departments_sbsr-rh/1597/
    Review by Coalition for Good Schools: https://coalitionforgoodschools.org/wp-content/uploads/2022/02/Coalition_for_Good_Scools_Evidence_Review_R6.pdf
    Review of UNHCR and partner practices: https://knowledgecommons.popcouncil.org/departments_sbsr-rh/1310/