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SITUATIONAL ANALYSIS ON POST-RAPE CARE OF CHILDREN IN LESOTHO

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

JUNE 2013

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ACRONYMS

AIDSTAR-One	AIDS Support and Technical Assistance Resources, Sector I, Task Order 1
ART	antiretroviral treatment
CCJP	Catholic Commission for Justice and Peace
CGPU	Child and Gender Protection Unit
CPWA	Children’s Protection and Welfare Act of 2011
CSA	child sexual abuse
CSOs	civil society organizations
DCPTs	District Child Protection Teams
ECSA-HC	East, Central, and Southern African Health Community
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FBOs	faith-based organizations
FIDA	International Federation of Women Lawyers
GBV	gender-based violence
GHI	Global Health Initiative
GOL	Government of Lesotho
HTC	HIV testing and counseling
HIV	human immunodeficiency virus
HIVnPEP	HIV non-occupational post-exposure prophylaxis
ICAP	International Center for AIDS Care and Treatment Programs
LENASO	Lesotho Network of AIDS Services Organizations
LCCU	Lesotho Child Counseling Unit
LSC	Lesotho Save the Children
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MOSD	Ministry of Social Development
MSH	Management Sciences for Health
NGOs	nongovernmental organizations
NOCC	National OVC Coordinating Committee
OVC	orphans and vulnerable children

PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PRC	post-rape care
PSS	psychosocial support services
STI	sexually transmitted infection
SWAALES	Society for Women and AIDS in Africa Lesotho
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USG	U.S. Government
VHWs	village health workers
VSGs	village support groups

INTRODUCTION

Scant data exist on the prevalence of violence against children worldwide. However, available information, including the United Nations (UN) Secretary-General's Study on Violence against Children, shows that violence against children is a global problem. Violence against and the exploitation of children include "all forms of physical or psychological abuse, injury, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse" (UNICEF 2011). Sexual violence, in particular, has a tremendous impact on reproductive health, mental health, and social wellbeing, and is associated with an increased risk of sexual and reproductive health problems, including unwanted pregnancy, pelvic inflammatory disease, infertility, gynecological disorders, and the transmission of the human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs) (Krug et al. 2002; UNICEF 2011).

Both the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the U.S. Government's (USG) Global Health Initiative (GHI) emphasize preventing, monitoring, and responding to gender-based violence (GBV) as critical to strengthening overall health outcomes. A key pillar of PEPFAR and GHI is the development of a coordinated, holistic response to GBV, including meaningful screening and counseling for GBV; strengthened collaboration between health care professionals, community-based social support networks, and legal systems; and timely access to and provision of HIV non-occupational post-exposure prophylaxis (HIVnPEP) (Day 2013). Alongside and within the focus on GBV is an increased focus on and concern about sexual violence and exploitation against children, which is often overlooked despite its relative prevalence and harmful consequences.

Evidence in sub-Saharan Africa shows that children who have experienced sexual violence and exploitation constitute a significant portion of those who seek services (Murray and Burnham 2009). Sexual violence and exploitation against children has been recognized as a critical developmental and human rights issue with important implications for HIV prevention, care, and treatment. Globally, an estimated 150 million girls and 73 million boys under the age of

BOX I. DEFINITION OF TERMS USED

CHILD WHO HAS EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION:

A person under the age of 18 years who has experienced an act of sexual abuse. Child exploitation is the use of children for someone else's economic or sexual advantage, gratification, or profit, often resulting in unjust, cruel, and harmful treatment of the child. This is the predominant term found throughout this document. (Day and Pierce-Weeks 2013)

CHILD SEXUAL ABUSE: The World Health Organization defines child sexual abuse as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust, or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

- the inducement or coercion of a child to engage in any unlawful sexual activity,
- the exploitative use of a child in prostitution or other unlawful sexual practices,
- the exploitative use of children in pornographic performance and materials. (WHO 1999; Day and Pierce-Weeks 2013)

VULNERABILITY: Defined as those children whose rights to survival, development, protection, and participation are not met because of certain conditions or circumstances beyond their individual control. (MSD 2012)

18 have experienced some form of sexual violence and exploitation (Pinheiro 2006). A literature review on child sexual abuse (CSA) conducted by the East, Central, and Southern African Health Community (ECSA-HC 2011) further suggests a high prevalence of all forms of sexual violence and exploitation against children in sub-Saharan Africa. Children are in danger of experiencing sexual violence and exploitation across multiple settings within the community, at home, and in the broader society (Population Council 2008; ECSA-HC 2011). These data confirm what has been known anecdotally throughout Africa and are further supported by findings from the Violence against Children Surveys.

Significant barriers impede the provision of meaningful, effective services for children who have experienced sexual violence. These include concerns with ensuring confidentiality, availability of HIVnPEP, limited training for providers in effective medical protocols (where they exist) for children who experience sexual violence and exploitation, and weak collaboration between medical, legal, and social welfare services and community-based prevention and support (Kilonzo et al. 2009).¹ Adult-oriented services (when available) are often unprepared to meet children's complex needs (Keesbury and Askew 2010). Sexual violence and exploitation against children differs in many ways from that of adults and therefore cannot be handled in the same way.

Sexual violence and exploitation against children is unique because of their economic dependence; their weak social position (especially for girls) and gender inequalities, including high rates of GBV; and the severe impacts of the HIV epidemic on family and community structures. Not unlike GBV against adults, GBV against children is surrounded by a culture of secrecy, stigma, and silence because it is viewed as a private matter, especially when the perpetrator is a family member. There is also limited awareness of children's rights, what constitutes violence, and when and how to report it (ECSA-HC 2011, as noted in Day and Pierce-Weeks 2013).

AIDS Support and Technical Assistance Resources, Sector I, Task Order 1 (AIDSTAR-One) undertook a number of activities in 2011 and 2012 to address some of the needs of children who have experienced sexual violence and exploitation. In April 2012 PEPFAR's Technical Working Groups on Pediatric Treatment, Gender, and Orphans and Vulnerable Children, in coordination with AIDSTAR-One and the Together for Girls partnership,² convened a one-day expert meeting to draft *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs* (Day and Pierce-Weeks 2013). The meeting brought together 28 people, including representatives from PEPFAR, the USG, and Together for Girls, as well as experienced providers (clinicians, behavioral scientists, and social workers) with wide-ranging 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 (PEP) for HIV. The participants represented 8 countries³ and 14 organizations.^{4,5} The participants' main goal was creating technical considerations to focus on care for children that is implemented and linked to other critical services, such as psychosocial care and legal support.

Concurrent with the development of these technical considerations, PEPFAR/Lesotho asked AIDSTAR-One to conduct a situation analysis to determine factors that support or hinder effective care for children who have experienced sexual violence and exploitation. The results will provide information on how to make

¹ Text from Day (2013).

² The Together for Girls partnership comprises five UN agencies, led by UNICEF, the USG through PEPFAR and its implementing partners, the U.S. Centers for Disease Control and Prevention's Division of Violence Prevention, the U.S. Department of State's Office of Global Women's Initiatives, and the private sector. The partnership was formed with the specific intent of ending violence against children with a particular focus on sexual violence against girls.

³ Democratic Republic of Congo, Kenya, Lesotho, Mozambique, South Africa, the United States, Zambia, and Zimbabwe.

⁴ Emory University School of Medicine; EnCompass LLC; Family Support Trust Clinic; Greater Nelspruit Rape Intervention Program; John Snow, Inc.; Liverpool VCT, Care, and Treatment; Livingston Pediatric Center of Excellence; Office of the U.S. Global AIDS Coordinator; Panzi Hospital/Panzi Foundation; Together for Girls; UN Children's Fund (UNICEF); U.S. Agency for International Development, Office of HIV/AIDS; U.S. Agency for International Development representatives from Mozambique and Lesotho; U.S. Centers for Disease Control and Prevention; and the Government of Mozambique.

⁵ For more information on this meeting, please see http://www.aidstar-one.com/focus_areas/gender/resources/technical_consultation_materials/prc

the technical considerations more feasible and relevant, and how to operationalize them in Lesotho and beyond. The activity will also provide information for PEPFAR/Lesotho on how to move forward with activities for children who have experienced sexual violence and exploitation. The activity was designed to prioritize learning about clinical care within the broader package of services needed by children who have experienced sexual violence. A similar assessment was also carried out in Mozambique.⁶

It should be noted that the term “child who has experienced sexual violence or exploitation” is used throughout this document rather than the terms “victim” or “survivor” (see Box 1).

⁶ See *Post Rape Care for Children in Mozambique: Assessment Report* (in development).

COUNTRY CONTEXT

Lesotho has the third highest HIV prevalence in the world (after Swaziland and Botswana); just fewer than one in four people are living with HIV (UN General Assembly Special Session 2010). Fifty-six percent of the population lives below the poverty line (Ramoseme et al. 2007), and over one-third of all children are orphaned (Ministry of Social Development 2013). Poverty, food insecurity, and high HIV prevalence are the biggest threats to the survival, care, protection, and development of Basotho children because these factors constrain the ability of households and communities to care for their own.

Lesotho is committed to and has made progress in advancing the health, wellbeing, and protection of children. However, available (though limited) data and anecdotal evidence on high levels of sexual violence and exploitation against children in particular suggest that more remains to be done. Although little consistent statistical evidence is available on the magnitude and nature of violence and sexual exploitation against children, the anecdotal evidence and reports that cases involving children are not reported suggest that available data do not reflect the true situation. The high HIV prevalence further increases the chances of infection among children who have experienced sexual violence and exploitation—making the issue vital to child protection, health, and survival (U.S. Department of State 2011a).

According to a 2011 study by the Ministry of Health and Social Welfare (MOHSW), just over one-third (33.8 percent) of all children in Lesotho, or 363,526 children, are orphaned. The majority of Basotho children are vulnerable to food and economic insecurity, and over half of all children live in poverty, with approximately 10 percent (approximately 100,000) of all children vulnerable to specific, serious challenges, and 2 to 3 percent (approximately 30,000) extremely vulnerable and in need of urgent, targeted assistance. The same study revealed that 5.8 percent of all households with children had at least one member who had experienced violence in the year before the survey (4.6 percent physical violence, 1.1 percent sexual violence, and 0.1 percent both physical and sexual violence). Overall, nearly one in ten (9.7 percent) respondents noted that in the year before the survey, they were personally aware of situations of sexual violence and exploitation in their immediate neighborhood, with figures especially high in urban areas. This suggests a very high rate of child sexual violence and exploitation, approximately 10,000 cases, affecting roughly 2 to 3 percent of all households (Ministry of Social Development 2013).

Lesotho's Child and Gender Protection Unit (CGPU) was established in 2002 as a specialized unit within the Lesotho Mounted Police Service under the Ministry of Home Affairs to respond to the persisting acts of violence against women and children and has branches in 11 separate police districts. In 2005, out of 668 cases of violence and exploitation reported to the CGPU, 339 (51 percent) were sexual, and of these, 166 involved children under the age of 18 (UNICEF 2006). Between January and June 2006, 789 cases of sexual and exploitation were reported, of which 179 involved children (UNICEF 2006). Data from the national police crime statistics collected between April and December 2009 indicated that there were 57 reported cases of neglect of children and 23 cases of assault against children,⁷ although as noted earlier, the true number of child sexual violence and exploitation cases was thought to be much higher (U.S. Department of State 2011b).

It is worth noting that while, anecdotally, many cases of sexual violence and exploitation against children occur at the hands of a family member, no data specifically focus on sexual violence taking place within the household. The few studies that specifically address child sexual violence and exploitation in Lesotho point to violence in schools, high rates of child marriage, child trafficking, and sexual exploitation generally. One study on perceptions, experiences, and observations of school violence in Lesotho (De Wet 2007) indicated that 10.7 percent of the 272 respondents shared the perception that some students at their respective schools

⁷ These cases included child neglect, common assault, abduction (forced elopement), and sexual assault.

raped fellow students. The study also found that some educators verbally, physically, and sexually abused their students. A further study highlighted examples of specific incidents of violence, including female students who were gang-raped by groups of boys and female students who agreed to satisfy teachers' sexual demands because of fear that the teachers would physically punish them if they rejected their advances (Ngakane, Muthukrishna, and Ngcobo 2012).

GOALS AND OBJECTIVES

The purpose of this situation analysis was to understand what supports and hinders effective care for children who have experience sexual violence and exploitation in Lesotho. The study examined the services being implemented, facilitated, or provided by community- and facility-based partners (USG-funded and other groups, including the Government of Lesotho [GOL]) for children who have experienced sexual violence and exploitation; what is working well; and where there are gaps. The situation analysis looked in particular for currently existing mechanisms that link health facilities and facility-based support to the community, and vice versa. It also focused on developing recommendations for PEPFAR/Lesotho regarding strengthening existing services and linkages between facilities and communities.

METHODOLOGY

This situation analysis used document review and key informant interviews in Lesotho. The assessment team reviewed both gray and published literature (documents on Lesotho, sexual violence and exploitation of children, and GBV) and documentation from various nongovernmental organizations (NGOs), civil society organizations (CSOs), faith-based organizations (FBOs), and other groups involved in providing services for children who have experienced sexual violence and exploitation. The desk review was supplemented with information from a broader AIDSTAR-One literature review, *National Response Efforts to Address Sexual Violence and Exploitation against Children in Lesotho: A Desktop Study*.⁸

The assessment team developed a semi-structured interview guide for all interviews (see Appendix B). The following key questions were developed for the situation analysis:

- What is the current context of care for children who have experienced sexual violence and exploitation?
- What frameworks, structures, and system currently exist?
- What entry points for children are currently being utilized?
- What are the existing health facility, legal, judiciary, and social support/community services?
- What mechanisms exist that link these services?

To ensure the appropriate mix of interviewees and districts, the assessment team worked closely with PEPFAR/Lesotho and PEPFAR-funded partners that focus on issues related to orphans and vulnerable children (OVC), such as Management Sciences for Health (MSH), Pact, and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). In-country interviews with individuals or homogenous groups representing an institution (e.g., a UN organization) or informal networks (e.g., village support groups) were conducted between July 31 and August 10, 2012, in Maseru and the Thaba Tseka and Leribe districts. The interviewees included implementing partners (international and civil society), officials of the national government (the Ministry of Social Development; the Ministry of Gender, Sports, and Youth; and CGPU), officials of the district government (district CGPU teams, district Child Protection Teams, social workers, nurses and counselors, and hospital administrators), and community stakeholders (village support group members and community leaders).

Using a snowball approach, each interviewee was asked for names of other informants, who were also contacted when feasible. The interview guide was modified with additional questions and probes when gaps were identified. The assessment team triangulated the data, identifying patterns and themes and ascertaining gaps in the review. Interviews were transcribed immediately, and then analyzed against the field notes to distinguish patterns and themes. Additional information was supplemented via follow-up calls and emails throughout August and September 2012. Data analysis was conducted within the framework of the key assessment questions listed earlier.

At the end of the field visit, a meeting with key stakeholders was held in Maseru, during which the assessment team presented preliminary findings, which were well received and helped confirm observations. The meeting also provided an opportunity to further refine recommendations and allowed stakeholders to strategize on how to increase coordination among the different players engaged in child protection.

⁸ This resource is available on the AIDSTAR-One website at http://www.aidstar-one.com/focus_areas/ovc/resources/reports/desktop_study_lesotho.

For the full schedule of meetings held and respondents interviewed, see Appendix A.

LIMITATIONS

It is important to note that this situation analysis had four primary limitations. First, the assessment team did not interview any children directly, and thus did not get their perspectives firsthand. Information related to children and caregivers was gathered from stakeholders, and particularly from community respondents and CSO representatives, who are in regular contact with children and caregivers. Second, the analysis findings cannot necessarily be generalized to all of Lesotho, because the assessment team's interviews were limited to people who were physically located in Maseru and the Thaba Tseka and Leribe districts (although many interviewees were familiar with the overall country context and spoke broadly). Third, the team was unable to interview a sufficient number of facility-based providers because it did not receive permission for such interviews from the MOHSW within the assessment time period. Although the team interviewed nurses, hospital administrators, and managers, the number of physicians was very limited. Fourth, because of time constraints, the assessment team was not able to fully explore all the aspects of the multi-sectorial child protection system (e.g., meeting teachers or school administrators in the education sector or magistrates in the judicial sector).

FINDINGS

What is the current context of care for children who have experienced sexual violence and exploitation?

Nearly all respondents reported high levels of sexual violence and exploitation against children in their communities and spoke strongly about the need for improved services. Several noted that the perpetrators are usually someone known by the child, often a family member such as a father, uncle, or mother's partner. Many respondents noted that sexual violence and exploitation against children in Lesotho is highly stigmatized and entrenched in a culture of silence. Respondents said this stigmatization, combined with weak supporting structures, results in few cases being reported by caregivers, families, or community members. A few also said health providers who identify sexual violence and exploitation during routine examinations are sometimes hesitant to report cases. Although respondents overwhelmingly felt that sexual violence and exploitation against children is a prevailing problem, they also noted that very few children present at either health facilities or to the police for sexual violence and exploitation.

We hear so much about rape cases, but they don't come. There is a big disconnect. Or they would bring children for care, but then parents would not disclose.—Health provider

Children are not being educated to report cases. Either a relative doesn't want to report or the child is given something to keep quiet.—Government representative

You often find nurses who know about a girl who has been raped but they didn't do anything about it.—CSO representative

The child goes to the health facility and is ill-treated by the nurses as soon as she comes in. The nurses say, "Why are you doing this [reporting a case]?" Even the doctor does. And, some would try to rape them again.—CSO representative

According to respondents, awareness of individual rights regarding sexual violence and exploitation against children, what constitutes sexual violence and exploitation, and when and how to report cases is limited. All CSOs reported that lack of awareness and very limited community structures that support children who have experienced sexual violence and exploitation place children at risk and limit the number of cases reported. Respondents repeatedly mentioned a number of structural barriers to reporting cases of sexual violence and exploitation against children, including poverty and economic constraints, which inhibit caregivers from reporting incidents if the perpetrator is the family breadwinner, relative, or caregiver; the shame and stigma experienced by the children themselves; and a system that offers little support to children and appears to protect the perpetrators. A number of respondents noted that cases are disclosed publicly only if a girl becomes pregnant and that cases are reported late (beyond the 72-hour window period for HIVnPEP). Many respondents said that when cases are revealed, families attempt to resolve the situation internally because they consider sexual violence and exploitation against children to be a private matter that should be handled quietly.

People don't come out to say that they are raped. They aren't straight.... People don't have faith in the system.
—Health provider

Family tends to think they can solve issues as a family.—Community representative

Often, vulnerable children wind up with an uncle who abuses them and is also the breadwinner. The immediate family will not tolerate whistleblowing—the family looks at it as if it is an embarrassment to the family, and they will also lose income if the uncle goes to jail.—CSO representative

When asked about the prevalence of sexual violence and exploitation against boys, nearly all respondents described severe underreporting, largely due to stigma as well as fear of retaliation by the perpetrator. Many respondents mentioned especially high levels of sexual violence and exploitation committed against herd boys.⁹ Children with special needs are another particularly vulnerable group, because they may be unable to voice instances of abuse. According to a CSO that serves disabled children, both the health and legal systems discourage special-needs children from reporting. It also indicates that families of children with special needs who have come forward have generally experienced unsatisfactory services.

Communities don't see it as important to report when it involves a child with a disability, because they don't see the disabled child as valuable.—CSO representative

People think that [a] person with mental disability is attracting abuse.—CSO representative

A number of respondents mentioned the damaging attitudes and beliefs that prevail in many communities and that may contribute to sexual violence and exploitation against children. For example, many respondents spoke about practices such as abducting girls for marriage or marrying girls as young as 14 to older men, and of the belief that sexual intercourse with a virgin will cure HIV. One CSO described instances in which village elders or leaders unwittingly repeated the violation of young girls who reported sexual violence and exploitation by making them disrobe. The elders or leaders then inserted their fingers into the girls' vagina to determine if they had experienced the abuse.

NATIONAL LAWS, POLICIES, AND FRAMEWORKS

What frameworks, structures, and systems currently exist?

Formal Acts of Law

Lesotho, a signatory to the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, has been praised for undertaking a lengthy process of legal reform in the sphere of child law. However, despite progress, mechanisms to operationalize these laws, influence national plans and programs, and monitor implementation remain weak (Pholo and Partners Consultants 2012).

The Sexual Offenses Act of 2003, enacted in response to pervasive rape and the escalating HIV crisis, was the first law to establish stiff penalties for rape, incest, and other offenses. The law recognizes marital rape as a criminal offense given certain conditions: if the accused spouse or partner has or is reasonably suspected to have an STI or other life-threatening disease, or if violence or threats are used to engage in a sexual act (NAC, World Bank, UNAIDS 2009). The law also contains specific sections that protect children against child prostitution and commercial sexual exploitation as well as their use in pornography (African Child Policy Forum 2012) and prohibits sexual abuse of children, molestation, and persistent child abuse. Under the act, it is an offense to engage in sexual relations, which includes exposing genitalia, conducting a sexual act in the

⁹ Herd boys are children who tend cattle and/or sheep, often in isolation for long periods of time in remote highland areas of the country.

presence of another, and inserting animate or inanimate objects, without the consent of the partner or the ability to give consent, in the case of children and the disabled. The act also makes it unlawful not to report a case of child sexual violence and exploitation, when such information becomes available (Zuberi 2005).

Children’s Protection and Welfare Act

The Children’s Protection and Welfare Act of 2011 (CPWA) came about in the wake of a marked increase in reported cases of sexual violence and exploitation against children (UNICEF 2011). The CPWA recognizes emerging child protection and welfare challenges brought on by Lesotho’s HIV epidemic and nationalizes international instruments on children’s rights (UNICEF 2011). The act defines “abuse” as “any form of harm or ill-treatment deliberately inflicted on a child. [This] refers to physical harm, sexual abuse, exposing them to a behavior that may harm the child, expose a child to physical or mental neglect, abandon or leave a child without visible means of support” (GOL 2011).

The act was guided by the principle that “the best interests of a child shall be the primary consideration for all courts, persons, including parents, institutions or other bodies in any matter concerning the child” (GOL 2011). Although the act has been recognized as vital for Basotho children and deemed a historic law, respondents repeatedly noted continuing delays and challenges with its implementation. The challenges include lack of public awareness about the act due to nonavailability of public copies, lack of subsidiary regulations, and absence of a fully budgeted implementation plan (Weber 2013).

Policies That Include Reference to Sexual Violence and Exploitation against Children

The *Lesotho National Strategic Plan on Vulnerable Children 2012–2017* replaces the outgoing *National OVC Strategic Plan (2006–2010)*. It identifies the Department of Social Welfare as the body responsible for providing leadership in the national response to vulnerable children, providing policy guidelines, and developing plans for Lesotho’s response to vulnerable children. The plan articulates a paradigm shift from a social welfare approach to a results-based approach that is grounded in principles of human rights and social development and that focuses more on child vulnerability rather than on a child’s orphanhood status (MSD 2012). The plan explicitly adopts a broad definition of vulnerability, as noted in Box 1, and builds on the definition that is provided in the CPWA.¹⁰

The plan also notes the different gender vulnerabilities of boys and girls, and states that stakeholders should take into account gender differences between boys and girls and the associated risks and vulnerabilities while developing their respective responses, noting, “During the implementation of the strategic plan gender dimensions that put [the] child at risk of new infections, violence and sexual abuse, or contribute to factors that disadvantage them socially, economically or otherwise will be addressed with special attention to the girl child” (MSD 2012).

Furthermore, the plan states that the Department of Social Welfare will coordinate monitoring and evaluation of service delivery in all the sectors that have a mandate to provide basic services for vulnerable children. The different sectors will be required to report the extent to which they reach vulnerable children with appropriate services (MSD 2012).

Some existing policies on HIV, gender, and OVC further acknowledge and reference issues relating to the prevention and timely management of sexual violence and exploitation against children. For example, Lesotho’s *National Strategic Plan on HIV and AIDS, 2006-2011* recognizes the importance of judicial-legal

¹⁰ The CPWA defines a vulnerable child as “a person who is below the age of 18, who has one or both parents who have deserted or neglected him, to the extent that he has no means of survival and as such is exposed to dangers of abuse, exploitation or criminality and is therefore in need of care and protection.” As the National Strategic Plan on Vulnerable Children notes, “This definition shows that it is limited to vulnerable children being deserted or neglected and hence does not cover all issues that make children vulnerable or put them on harm’s way.” Therefore, the definition in the National Strategic Plan on Vulnerable Children expands on this definition to encompass all the factors that make a child vulnerable (MSD 2012).

reforms that provide a supportive environment for women and girls and that reduce the high prevalence of HIV in Lesotho. It also recognizes that legal reform on gender equality has been slow to materialize and that this, as well as widespread sexual exploitation, is contributing to the HIV epidemic. The *2011–2016 National Action Plan for Women, Girls, and HIV/AIDS* highlights the CGPU as being responsible for providing services to survivors of GBV and investigating cases of infants and children in need of care.

Norms and Protocols to Guide Practice in Sexual Violence and Exploitation against Children

There are currently no guidelines, protocols, services, or standards of care specifically tailored to the unique needs of children who have experienced sexual violence and exploitation. The MOHSW did develop *Guidelines for the Management of Survivors of Sexual Abuse in Lesotho* in 2005, which was adapted from World Health Organization guidelines (MOHSW 2005). However, the MOHSW guidelines focus on the needs of women. The assessment team was unable to acquire a set of these guidelines from either the ministries or district-level facilities, and it is not clear whether or to what extent these adult guidelines are being utilized.

EXISTING STRUCTURES AND SYSTEMS

National Level

Many different ministries play a role in addressing sexual violence and exploitation against children, including the Ministry of Social Development (MOSD), the Ministry of Health (MOH), the Ministry of Education, Gender, Youth, Sports, and Recreation, the Ministry of Justice, Human Rights, and Correctional Service, and the Ministry of Home Affairs. As other recent reports have noted, and as respondents consistently pointed out, coordination across the relevant ministries appears to be severely lacking in terms of support to vulnerable children in general and sexual violence and exploitation against children in particular.

Although all ministries have a role to play in addressing sexual violence and exploitation against children, ownership of the problem is seen as resting most naturally with the MOSD, which has a mandate to ensure that every child is in a place of safety, and also oversees the OVC response. A number of respondents pointed out that the June 2011 reconfiguration of the MOSD (which was formerly part of the MOHSW) as a separate ministry provides an opportunity to champion the response to sexual violence and exploitation against children. With this split, the MOSD has now shifted its response from welfare to development, with social protection as the main focus. The mission of the new MOSD is to work with other stakeholders to lead and facilitate the provision of sustainable social development services that are universally accessible to all groups in Lesotho. In particular, the ministry has as some of its key objectives to “protect and promote the rights of all poor and vulnerable groups to ensure that their basic needs are met” and to “advocate and lobby for prioritization of the needs of the poor and vulnerable groups in the national development agenda and all aspects of life” (MOSD 2012).

As part of these larger changes, social workers have been given new statutory authority, and a Child Welfare Office has been created. Although interviews with the MOSD reveal commitment to addressing sexual violence and exploitation against children, respondents pointed out that the effectiveness of the MOSD’s response and its efforts to define, strengthen, and manage institutional arrangements and linkages remain to be seen.

Another potentially important national player in the fight against sexual violence and exploitation against children is the National OVC Coordinating Committee (NOCC), which consists of key national ministries and development partners, NGOs, and FBOs that provide services to OVC (Ministry of Social Development 2013). The NOCC is tasked with meeting regularly to share information. However, the committee has no statutory powers, legal status, or independent funding, and respondents suggested that its leadership and coordination on OVC issues has been weak. According to respondents, the NOCC has not prioritized a response to sexual violence and exploitation against children as a key part of its mandate.

District Level

There are a number of key bodies at the district level that play a role in child protection. District Councils act as a corporate body with jurisdiction over the whole district and have two members representing each community council, plus two gazette chiefs of the district (who are members of the community councils). District Child Protection Teams (DCPTs) are relatively new and consist of agencies that are responsible for various aspects of service delivery and safety for children. As independent structures, the DCPTs are chaired by the MOSD and tasked with coordinating and sharing information related to OVC. However, as with the NOCC, the DCPTs have no statutory powers, legal status, or independent funding.¹¹ There is currently some capacity building of DCPTs by NGO partners; however, the majority of respondents stated that DCPTs are generally not well known or not (yet) functioning in many areas.

DCPT? They are not functioning in my village. Is this for an initiative? A project? We don't know much about them.
—Implementing partner

DCPT is not well known.—Government representative

The Office of the District Social Welfare Services is designed (under a recently proposed structure) to support and coordinate responses for target populations via four departments: 1) District Clinical Social Welfare Services, 2) District Elderly Care Services, 3) District Child Welfare Services, and 4) District Social Rehabilitation Services (Ministry of Social Development 2013). Despite the potentially significant role that district social workers (DSWs) could play in the response to sexual violence and exploitation against children, all respondents, including DSWs and the MOSD, reported that social workers were not currently functioning optimally. There is a very limited number of the DSWs at the district level, and they are insufficient in number to cover the needs of their area. Respondents felt that until this workforce increases in size, social workers do not have the capacity to manage services or play a large role in the response to sexual violence and exploitation against children at the district or sub-district levels. A further challenge, interviewees said, is that very few district-level officers have specialized training, and this shortage of skills hampers the technical implementation of specialized child welfare services (Tamasane et al. 2011). As one social worker noted, “We are only social workers, trained as generalists. We don't have CSA specialty training.”

The MOSD is introducing a new cadre of community council–based Auxiliary Social Welfare Officers to provide improved community-level support, supervised by District Child Welfare Officers under the District Child Welfare Services. As of August 2012, 30 Auxiliary Social Welfare Officers had been deployed, toward the goal of three per community. It remains to be seen how effective these new officers will be.

As noted earlier, the CGPU was established by the Ministry of Home Affairs in 2002 as a specialized unit within the Lesotho Mounted Police Service to provide law enforcement services for crimes against women and children, especially abuse and domestic violence. The CGPU is tasked with operating nationwide, with branches in all 10 districts. See the section Legal and Judiciary Services for a further discussion on the CGPU.

Community Level

Respondents said there are three important structures at the community level that address sexual violence and exploitation against children: community councils, village support groups (VSGs), and village health workers (VHWs). Community councils consist of representatives from a cluster of villages in rural and urban areas (Mwase et al. 2010). These legally recognized structures are administratively linked to the Ministry of Local Government and Chieftaincy, perform functions delegated by the district council, and draw staff and other resources from the district council. In theory, social workers are supposed to support these councils to shape and implement the operational aspects of the CPWA.

¹¹ However, noting the current work planning process, one respondent mentioned it is possible that some budget may become available.

VSGs are informal village-based structures. Many of these groups focus on providing care and support to people living with HIV and support for OVC and their households. According to two respondents, VSGs have grown in size and stature with the influx of HIV funding. Some VSGs have received funding from local and international NGOs to address child protection as part of their general mandate, although they have not engaged systematically with the formal system to address CSA. VSGs vary from community to community in size, strength, and level of activity, and appear to be inconsistent in terms of the level of support they receive. As indigenous structures, VSGs draw on the strengths and energies of community members and are generally poorly coordinated, with little to no investments made in capacity building. Many respondents from VSGs felt they have been underutilized and could play a potentially important role in the response to sexual violence and exploitation against children.

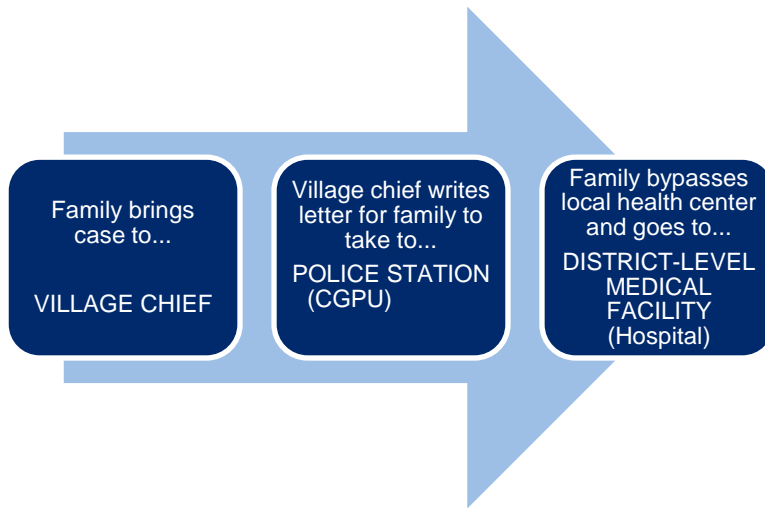
There was a case of an 11 year old girl raped by a villager. The chief made a decision that the rapist should marry the girl. If that had happened with a support group available, such a decision would not have taken place.—Community stakeholder

VHWs are tasked with delivering basic health services at the community level and creating demand for facility-based services through social mobilization. Their mandate, on paper, is to provide child protection and development in the community and to serve as a link between the facility and community (Mwase et al. 2010). However, nearly all respondents said that the VHWs are not playing a major role in their communities for any services, including child protection, and that tensions exist between this cadre and VSGs. Respondents said the VHWs are aging and no longer able to play active roles in the communities. It was felt the VHWs are not properly trained and, in many cases, no longer functioning—challenges that are compounded by the lack of community outreach programs rooted at the health facility level.

What are the entry points for children currently being utilized?

Cases of sexual violence and exploitation against children are reported in communities through several pathways. Some respondents said the most common referral pathway begins with a family member or caregiver reporting the case to the village chief, who provides that person with a letter stating the validity of the case. The person takes the letter to the police station and is triaged to the CGPU. The family member or caregiver is then given a Sexual Offense Inquiry Form and sent to a local health center, where a doctor examines the child and completes the form.

Figure I. Most Commonly Cited Reporting Pathway



However, other respondents said the child is usually brought to a district-level health facility such as a district hospital, bypassing the local health center (see Figure 1). For the Sexual Offense Inquiry Form to be valid in court, the medical portion of the form can only be signed by a medical doctor from a government health facility, and doctors are infrequently found at local health centers. Respondents suggested this may limit the number of children who access care, because many families cannot afford to travel to a district-level facility.

Interviewees said that in cases of abuse, families are more likely to report to the chief and then the police, rather than going directly to a health facility for medical care. One reason for this is that the Sexual Offense Inquiry Forms are located at the police station. Respondents did not know why these forms are not made available at health facilities or with the chiefs to facilitate faster access, but anecdotes from the interviews show that this situation could inhibit the provision of timely medical care. For example, respondents shared cases in which caregivers who presented at a health facility were told to report to the police first to obtain the form because the facility would only conduct the examination if the caregivers had the form in hand. Respondents also spoke of having to “run around” during the critical 72 hours between visits to the chief, police, and health facility. “The result is that patients are thrown back and forth between the hospital and CGPU systems,” one respondent said.

What are the existing health facility, legal, judiciary, and social support/community services?

What mechanisms exist that link these services?

HEALTH FACILITY SERVICES

Respondents described the severe challenges that children and their caregivers face in accessing quality medical care. These challenges include delays in accessing a doctor once at the facility; doctors and nurses who are insufficiently trained to address the needs of a child who has experienced sexual violence and exploitation; stockouts of HIV test kits; lack of privacy at the health facility; limited coordination and communication among health facility staff, CGPU members, and social workers; lack of immediate or longer-term counseling and other psychosocial support; and poor follow-up care and referrals.

As noted earlier, Lesotho has no national protocols for the delivery of clinical services for children who have experienced sexual violence and exploitation. Such protocols would ideally include information on establishing services tailored to the unique needs of children, preparing for and performing a head-to-toe physical examination, collecting forensic evidence, and ensuring follow-up care and referrals for psychosocial and community support services. Respondents said health care providers apply the same standard of care for children as is practiced for adults who have experienced sexual violence and exploitation (see Box 2). They said that rape kits of any sort are rarely or never available, that physicians rarely work at the health-center level, that health centers seldom provide treatment for STIs, and that HIVnPEP is not readily available in health centers. They also said that doctors do not fill in the Sexual Offense Inquiry Forms correctly.

The form that the police provide is used at the trial only. But the form is sometimes not accurately completed. For example, sometimes one is brutally whipped. The doctor has to describe the nature [of the whipping], but will mostly indicate “light.”

—CSO representative

There is also confusion over the payment of fees. According to respondents, clients were told that a facility would only agree to provide free services if the child had already reported a sexual violence and exploitation case to the police and had the official form. Although the CPWA states that “a child who is presented to a Medical Officer under subsection (1)¹² should be exempted from

BOX 2. MEDICAL TREATMENT FOR CHILDREN WHO EXPERIENCE SEXUAL ABUSE

As conveyed by respondents, the medical procedures for children presenting with sexual abuse include the following:

HIV testing and counseling (HTC): If test kits are available, the child is tested for HIV and, if negative, asked to return for HTC after three months. If the test results remain negative after three months, the child is retested in six months. If any of the tests are positive, the provider requests a baseline investigation and refers the patient to an antiretroviral treatment (ART) clinic for further management.

PEP: Those who receive HTC and are eligible (presented less than 72 hours of the rape) are provided with PEP to prevent sero-conversion.

STIs: The child is screened for syphilis, gonorrhea, and chlamydia (Venereal Disease Research Laboratory and urinalysis) and given antibiotic prophylaxis to prevent STIs. A High Vagina Swab is also taken and sent to the laboratory to look for the presence of spermatozoa.

Pregnancy: The girl-child is given a pregnancy test and family planning is provided if the result is negative.

The providers also complete the Sexual Offense Inquiry Forms and send them to the police for further legal management.

¹² Subsection (1) states: “A medical officer before whom a child is presented under section 26(1): (a) shall conduct or cause to be conducted an examination of the children; (b) may, in examining the child and if so authorized by a social worker or police officer, administer or cause to be administered such procedures and tests as may be necessary to diagnose the child’s condition; (c) may provide or cause to be provided such treatment as the medical officer considers necessary as a result of the diagnosis.”

medical fees with the authority of the Department of Social Welfare (Part VI, 481),” it was not clear to respondents what (if any) authorizations are needed from the **Department of Social Welfare** or others to waive any fees, or if caregivers who present with a child who has experienced sexual violence and exploitation are automatically exempted from any payment.

A number of respondents said that nurses at the district hospitals and sub-district health centers were unfriendly and unsympathetic toward children who presented for sexual abuse or felt that dealing with these cases was not their responsibility. District-level nurses acknowledged that some nurses may seem unfriendly.

We are overloaded with too many [general] cases, over sixty a day ... when we go to clinics, starting from our schooling, we see [nurses] with different [i.e., undesirable] attitudes. Then it influences us. We don't like when [children] ask questions; because we're nurses, we're not used to giving more information. We feel they are challenging us.... The working conditions are poor.

—Health provider

The nurses see that a case is a sexual violence and exploitation against children case and immediately determine that it is the physician's responsibility and not their own. So they don't pay attention to any of the child's needs.—CSO stakeholder

We don't take [children who have experienced sexual violence and exploitation] to clinics since nurses' attitudes are terrible. People would rather go to private doctor where they are treated better. Or, they say, I'd rather stay at home and die than face the government clinic.—Community stakeholder

The assessment team was unable to interview an adequate number of doctors directly, but some respondents reported that doctors avoid cases of sexual violence and exploitation against children because they are hesitant to be witnesses in court trials or feel there is no point. There is no witness protection, and witnesses are often treated poorly by judges, lawyers, and others involved in the process. Respondents reported two recent cases in which health providers said they were unwilling to prepare the Sexual Offense Inquiry Form because they felt that it was a waste of time and that no justice would be served.

A number of respondents said that there were few or no linkage mechanisms between the CGPU and the health facilities and that police were often unwilling to fill out the reports needed to file a case or to help facilitate referrals. One interviewee said facilities had tried to increase police engagement in cases of sexual violence and exploitation of children, but found them extremely difficult to work with “or even [get them to] do their jobs.”

The situation analysis found limited guidance for health facilities on how a referral system for children who have experienced sexual violence and exploitation should function, or what follow-up such a system should include. Respondents repeatedly said health workers had limited understanding of their responsibilities for children's wellbeing beyond HIVnPEP, emergency contraception, and HIV and STI treatment. Although in theory social workers are supposed to be assigned to each case of a child who has experienced sexual violence and exploitation, respondents described them as unclear on their role and unequipped for case management, even in terms of initial counseling in the facility.

LEGAL AND JUDICIARY SERVICES

A number of respondents noted that even though the very existence of the CGPU is a promising step toward addressing sexual violence and exploitation against children, it appears the system is functioning poorly.

When people are accused or jailed, they have more rights than the victim.—CSO representative

The papers have so many cases, yet perpetrators get less [jail] time than a thief.—Health provider

Nearly all respondents revealed concerns about the CGPUs' services. Many expressed concern that the way police handle cases may cause secondary trauma for children and their caregivers, which may contribute to the reluctance to report cases. One CSO representative described the CGPUs' police-child interaction as more like an interrogation, lacking sensitivity to the special needs of children who have experienced sexual violence and exploitation.

At the police station, it is like children are raped again.—Health provider

Respondents noted there is limited confidentiality and a limited sense of safety for children and their caregivers because the CGPUs are located in police stations, most often without a separate section for private discussion. Although some donors have supplied container units so the CGPUs can be physically separated from the main police unit, these spaces are purportedly used for storage and not for their original intent. One CGPU officer described ways children feel vulnerable in the CGPU where s/he operates, saying that children and caregivers who come from distant villages often stay the night in the reception entrance, where they are asked the same questions by different officers who pass by.

Many interviewees said CGPU staff receive no specialized preservice training and limited to no in-service training, particularly for counseling. Although it appears that CGPU staff received some training and exposure to child-related legal cases in 2006 and 2007 through the UN Children's Fund (UNICEF) and the International Federation of Women Lawyers (FIDA), it was not clear to the assessment team if CGPU staff had received any consistent refresher training or if any CGPU officers were currently receiving any child-specific training. According to CGPU staff, there are no dedicated cadres currently specializing in sexual violence and exploitation against children at the police academy. Apparently, some officers receive on-the-job training by watching their peers perform, but these staff reported feeling deficient in several skills, including providing psychosocial support and preventing further trauma during the questioning. Many respondents said that frequent and indiscriminate transfers of trained CGPU staff creates barriers to effective responses to sexual violence and exploitation against children. As one CSO representative stated, "For CSA there is no training. And the good ones [CGPU officers] leave. Before you know it, they get transferred. It's really a challenge."

Several respondents noted that the overall emphasis of the police is on the perpetrator, with insufficient attention to the victim's wellbeing. Police are evaluated on their ability to formulate a case against a perpetrator, rather than on their abilities to attend to the child and caregiver.

What you find here is that a father abuses a child, will be in police station for two days and then returns to household, and abuses the child.—CSO representative

This review did not investigate the court system and legal processes in detail. However, respondents provided secondhand information based on their personal dealings with cases. They cited a number of serious inadequacies in the court system, including:

- Absence of advocates for victims
- Absence of witness shelters before trial
- Unskilled and ill-trained prosecutors (with perceived lack of will to bring perpetrators to justice)
- Frequent release of perpetrators on small amounts of bail
- Excessively lengthy processing and resolution of cases
- Stigma and discrimination against the plaintiffs during the court procedures and processes, including public stigma and discrimination as a result of indiscriminate media use of journalistic license and access to cases.

Although there are a number of CSOs in Lesotho that provide support for children and caregivers faced with a legal case, these organizations are not recognized by the courts or allowed to play an official role. A national Victims Support Office does exist, but it is staffed by only three people. As previously noted, respondents reported hesitancy on the part of medical providers to get involved in court proceedings. Similar sentiments were noted by social workers, one of whom said, “We have phobia standing in front of the magistrate. We haven’t practiced or taken the responsibility to try to do it.”

SOCIAL SUPPORT AND COMMUNITY SERVICES

Once the child and caregiver leave the health facility, there appear to be few or no case follow-up mechanisms for the health facility staff or social workers. Typically, DSWs are tasked with case management to ensure follow-up in key areas of care, including HIVnPEP, counseling, community coordination, and other health and social needs. However, respondents said this follow-up is not taking place. Social workers interviewed at the district level agreed that they need to play a more active leadership role to this end. One said, “I believe we haven’t raised enough awareness as to how we can play a role. We aren’t very known in communities.” For HCT follow-up, it appears that the onus is on the caregiver and child to return to the facility at the recommended times. In some cases, VSGs provide some follow-up services for children and caregivers in their communities, but in an ad hoc manner and without any formal linkage to the health facility.

Nearly all respondents reported that there are little to no institutionalized community-level psychosocial support services (PSS) for a child or caregiver after leaving the health facility.

No one helps the child through trauma [in] the community.—Community representative

One girl was very traumatized from the court processes. The first day in court she didn’t make sense. [The prosecutor] just yelled out, “Go for counseling.” And the mother said, “Where?”—CSO representative

Services that do exist are sporadic, donor funded, and typically inadequate to deal with the short- and long-term effects of sexual violence and exploitation. Respondents pointed out the need to support the caregiver as well as the child.

Relatives are also traumatized. If [a] child is raped, anyone surrounding the child feels the pain. Even the community.—CSO representative

We need to rehabilitate the entire family [after an incident]. The parents, or people living with the child, and other community members. We need counseling that involves everyone.—Health provider

The emergency and interim care options for children who have experienced sexual violence and exploitation in Lesotho are largely run by civil society or by individuals. There are no government temporal care options, and the Department of Social Welfare refers cases to civil society or the private sector.

THE ROLE OF CIVIL SOCIETY

Although various initiatives exist to address sexual violence and exploitation against children, respondents mentioned how challenging it was for civil society to engage in this issue.

When we raise these issues, the community reacts as if we are investigating them. It is very difficult for us to engage in this area.—CSO representative

It appears that the majority of initiatives to address sexual violence and exploitation fall under OVC programming, of which child protection is one component. This programming also includes conducting prevention and awareness-raising of sexual violence and exploitation of children, training community workers to recognize signs of this abuse, and selecting projects or programs that support temporary homes and services for severely vulnerable children. A few efforts aim to strengthen existing child protection systems, although these appear to be limited in scope and reach, such as offering comprehensive care, including nutrition, providing referrals to basic health care, and household economic strengthening; and supporting programs such as Kids' Clubs, and support to VSGs for various initiatives, mainly around HIV.

Other than CSOs offering temporary housing on referral from DSWs, it does not appear that many civil society initiatives are consistently linked into the formal child protection system. For example, two CSOs rely heavily on the media to alert them when cases of CSA arise, after which they make contact with the family to provide support.

Civil Society and Systems Strengthening

There are a number of initiatives to strengthen the overall child protection system. Under the Building Local Capacity for Delivery of HIV Services in Southern Africa Project, which is funded by PEPFAR through USAID and implemented by MSH, systems-strengthening activities are working to build the capacity of social workers by providing leadership development training for senior staff at the MOSD, fortifying community-based referral mechanisms, and coordinating responses to the needs of OVC and their caregivers. Under the Community Rapid and Effective Action to Combat HIV/AIDS program, which is funded by PEPFAR through USAID, PACT provides NGO, CBO, and FBO partners with technical expertise to help them deliver effective programming, as well as capacity building to increase their ability to provide HIV services. UNICEF also provides support for systems strengthening, largely through a social protection program to build a national social safety net with services for vulnerable children.

Civil Society and Clinical Services

As a partner in the Nurse Education Partnership Initiative, funded by PEPFAR through USAID, the International Center for AIDS Care and Treatment Programs (ICAP) works with the GOL to increase quality and quantity of nursing services in Lesotho. This will include reviewing and revising nursing curricula for pre- and in-service training and moving from a content-based to a competency-based curricula. ICAP will be developing the competencies for nurses to provide child welfare services, including management of all forms of abuse, including services for children who have experienced sexual violence and exploitation. Under

BOX 3. KEY PROVISIONS IN THE CPWA THAT ARE RELATED TO SEXUAL VIOLENCE AND EXPLOITATION AGAINST CHILDREN

- That all actions should be in the best interest of the child, prioritizing the rights, health and welfare of the child over that of the needs to prosecute the perpetrator (Part II, 469).
- That a child who has experienced sexual violence and exploitation shall, as soon as possible, be provided with emergency legal, medical or health assistance (Part XXV, 637).
- That representatives from the DSW, police, chief or member of the community [who takes a child into a place of safety] can bring the child directly to a Medical Officer (Part IV, 480–481).
- That a child who is presented to a Medical Officer under the aforementioned circumstances should be exempted from medical fees with the authority of the Department of Social Welfare (Part VI, 481).
- That it is the legally binding responsibility of Medical Officers to inform a social worker or police officer if s/he is of the opinion that a child s/he is examining or treating is physically, psychologically or emotionally injured as a result of being ill-treated, neglected, abandoned or exposed, or is sexually abused (Part VI, 484).
- That the same is spelled out as the duty of the family, the child care provider and of the community (Part VI, 485).

PEPFAR, EGPAF is the GOL's primary HIV and AIDS partner in care and treatment and prevention of mother-to-child transmission of HIV and supports the GOL to scale up HIV services (including PSS) in all the districts of Lesotho. Its work includes helping to ensure that PEP is readily available in all health facilities and building the capacity of health care workers to administer PEP, manage STIs and HIV and AIDS, and increase adherence to the MOH national guidelines.

Another major clinical actor in Lesotho is the Baylor International Pediatric AIDS Initiative (Baylor), which operates the Baylor-Bristol-Myers Squibb Children's Clinical Center of Excellence in the capital, Maseru, and satellite centers of excellence in Qacha's Nek and Leribe districts. Baylor also provides medical expertise, clinical supplies, and professional training to an additional 82 health centers and hospitals run by the MOH throughout the country. Even though Baylor does not deal directly with CSA, providers do ask questions about sexual abuse when evaluating for modes of transmission with its adolescent clients, although not for younger children unless there is a questionable symptom or situation. In 2011 the initiative began raising issues of GBV and sexual abuse in adolescent clubs. Baylor has also received referrals from the CGPU and health centers when children test positive for HIV.

Civil Society and Awareness Raising/Advocacy

Child rights advocacy is an important responsibility that needs to be disseminated and rolled out in light of mandates of the CPWA (see Box 3). The Catholic Commission for Justice and Peace (CCJP) and the FIDA play important roles to that end. By working with communities to provide awareness raising and training on rights and empowerment, they are able to work closely with the government to advocate for prompt implementation of the law. Various CSOs such as Touch Africa and the NGO Coalition on the Rights of a Child also work on advocacy for child rights. Pact's training for civil society partners on sexual violence and exploitation of children focuses on raising awareness and planning for prevention. Participants are encouraged to take an active role in protecting children and youth and are given skills to develop policies and plans to prevent sexual violence and exploitation against children.

Civil Society and Community Support

At the community level, partners such as the Lesotho Network of AIDS Services Organizations (LENASO), the Society for Women and AIDS in Africa Lesotho (SWAALES), and others work directly with communities and VSGs to ensure their support for OVC. Groups such as the Lesotho Society of Mentally Handicapped Persons, Parents, and Families target special-needs and disabled children. They work to provide these children and their families with psychosocial support and life skills, while also training them on their rights and responsibilities and on how to report cases of sexual violence and exploitation.

Civil Society and Legal Services

A number of CSOs provide legal services. For example, the FIDA consults with community members to provide public education around legal rights, including the rights of children. The FIDA also provides legal aid when possible and supports paralegals at the village level to support cases of children who have experienced sexual violence and exploitation (among other cases). Lesotho Save the Children (LSC), in partnership with the (former) MOHSW, UNICEF, Global Fund, VODACOM, and Econnet Telecom Lesotho, also launched a Child Helpline in April 2008. The helpline is a phone-in and outreach service for children in need of protection from any form of abuse, violence, exploitation, or neglect. The helpline provides emergency assistance and links children to other service providers, as needed, to keep children safe.

Civil Society and Temporary Homes

As noted earlier, emergency and interim care options for CSA, including temporary housing, are largely run by civil society or by individuals. Respondents said there is no regulation of these temporary homes, and although some offer strong services and a place of safety, others are weak and may offer questionable services

for vulnerable children. Among these temporal homes are the LSC, the Selcamaneng/Kananelo Centre, Good Shepard, Beautiful Gate, Bana Trust, the Beautiful Dream Society,¹³ the Lesotho Child Counseling Unit (LCCU), the Mantsase Children's Home, and the SOS Children's Villages of Lesotho. These organizations offer varying levels of service, often depending on funding levels. For example, the LSC provides children with a safe home, food, clothing, medication, education, and psycho-therapeutic support while investigation into their situation is being carried out. It also offers a program to reunite children with their parents, extended family, and foster or adoptive family.

¹³ For trafficking victims.

SUMMARY OF FINDINGS

Lesotho is committed to, and has advanced, the health, wellbeing, and protection of children, and there are promising efforts under way to address the needs of vulnerable children. However, it is clear that more remains to be done:

- *Legal loopholes:* Common law and customary law may be in conflict with each other (or at least poorly aligned), with customary law being permissive. Although the CPWA provides some safeguards to protect children and their caregivers, mechanisms to administer this act and other laws are weak, resulting in poor implementation of national plans and programs (Pholo and Partners Consultants 2012). Subsidiary regulations, a budgeted implementation plan, and clearer guidance on the child protection system are lacking. Similarly, there is an overall absence of multi-sectoral coordination. The lack of cohesive strategic guidance on comprehensive child protection, inclusive of child sexual violence and exploitation, likely contributes to the generally disjointed response and is one of the major challenges to coordinating responses across different actors more specifically.
- *Unclear roles and responsibilities:* At the ministerial level, it is not clear where the issue of violence against children sits. Although the MOSD is responsible for providing leadership in the national response to vulnerable children, and the Ministry of Education, Gender, Youth, Sports, and Recreation holds the mandate to coordinate gender mainstreaming throughout national and sector development policies and programs, there is no clearly articulated mandate on which body is responsible for addressing issues of violence against boys and girls.
- *Inadequate coordination of efforts:* Various groups and organizations at the community level are working to address sexual violence and exploitation against children. However, limited coordination and collaboration, and a lack of strategies to link civil society responses into formal GOL systems, limit the scope and effectiveness of their work. The absence of national guidance on how a child protection and referral system for children who have experienced sexual violence and exploitation should function hinders the effort. The overall impact is that the system is not functioning to provide either emergency services or effective follow-up care. Referral systems among community services, the CGPU, and health facilities seem informal at best, lacking formal linkages or clear guidance on linking these different components, and without sufficient service organizations or staffing levels to make it feasible to access quality services.
- *Limited engagement by health care providers:* Respondents gave no sense that health providers felt an obligation to ensure the wellbeing of the child beyond the medical examination. For Lesotho to have an effective response, there must be a shift so that providers are clear on their roles and responsibilities in preparing for and responding to children who have experienced sexual violence and exploitation in a holistic way.¹⁴ For example, it is critical that these health care workers collaborate with a range of stakeholders—including law enforcement and the judiciary, social welfare services, CSOs, community groups, organizations representing people with disabilities, and other agencies—to help meet the complex needs and rights of children who have experienced sexual abuse. Providers' first responsibility is to offer health

¹⁴ This includes providing medical care that encompasses treatment for injuries and prevention of long-term disease and consequences from the violence; collecting forensic samples; screening for sexual violence and exploitation; communicating with children in a compassionate, understanding way; recognizing the impact of sexual abuse on long-term health and wellbeing; documenting the pertinent medical forensic history; documenting injuries and conducting a physical assessment; screening, counseling, and treating for HIV and other STIs; offering HIVnPEP; preventing unwanted pregnancy; filling out the police forms accurately; providing appropriate community-based resource referrals; providing referrals to other care and services (depending on what the child needs and wants); and providing testimony in court if required (Day and Pierce-Weeks 2013).

care services, but they must also recognize their role as part of a team responsible for providing a coordinated range of services to children and adolescents who have experienced abuse (Day and Pierce-Weeks 2013).

- *Confused reporting procedures:* When a family/child desires to seek medical care, there appears to be three main (potential) obstacles: 1) the perception that a family has to report to the police first before seeking medical attention; 2) the need to visit a district-level government facility for any sexual violence and exploitation services, rather than going to a more local facility; and 3) the need to go to a doctor, rather than seeking care from a nurse. Reporting to the police should not be a prerequisite for obtaining medical care, and the child should be offered all available services, including HIVnPEP, even if there is no physician available to sign the medicolegal forms or if the child or caregiver chooses not to report to the police. It is promising that in Lesotho there exist initiatives¹⁵ to develop child welfare competencies for nurses that will include management of all obstacles to good health, including all forms of abuse. This approach should help increase the understanding of sexual violence and exploitation against children as a health issue that should be integrated into both maternal and child health and primary health care interventions, so it can be handled appropriately in diverse clinical settings by providers other than doctors.
- *Lack of community-level resources:* At the community level, there is very limited availability of social services; in particular, the assessment team did not find evidence of any structured case management follow-up for children and caregivers or any PSS support.
- *Strong indigenous practices:* In general, there are clearly indigenous practices at play at the community level, such as the inclination to resolve issues within families and communities, as well as the critical role of the chief in reporting cases of sexual violence and exploitation against children. These issues were not explored in detail during the situation analysis, but will be important to consider when developing responses—as any effective response must build on the strengths of such indigenous and common practices.

¹⁵ Under the ICAP.

RECOMMENDATIONS

Based on the analysis of existing services for children who have experienced sexual violence and exploitation in Lesotho, the following recommendations are offered to help PEPFAR/Lesotho strengthen services for these children and their caregivers and ultimately strengthen programming and outcomes.

Mobilize political will and resources to end sexual violence against children.

Government commitment to fulfilling child protection is essential to a protective environment and an effective response. This requires multi-sectorial coordination, especially among the health, education, legal, judicial, and social development sectors. The Ministry of Finance and donors should also be included to ensure follow-up and resources for action. Important actions include:

- *Establish accountability:* Help the GOL to formally and publically identify who “owns” violence against children in general and sexual exploitation and violence in particular (which is generally understood to be the MOSD, but this is not entirely clear).
- *Link the issue of sexual violence and exploitation against children to health:* Support activities to help stakeholders understand that sexual violence and exploitation against children is not only a child protection issue but a critical health issue, and link the highly active HIV response with GBV and the sexual abuse of children in-country responses (focusing on GBV and CSA as structural drivers of HIV).
- *Coordinate roles and responsibilities:* Support the creation of a task force that focuses on sexual abuse against children, with the goal of harmonizing and clarifying the roles and responsibilities of the different government sectors. The task force should develop clear terms of reference and a set of actionable milestones. Responsibilities and activities should be consistent with the CPWA (see below).
- *Learn from other programs:* Conduct a structured learning visit for key decision makers to learn from regional post-rape care (PRC) programs, such as the Greater Rape Implementation Program in South Africa and the Livingston General Hospital Child Sexual Abuse One-Stop Centre in Zambia.

Support the implementation of effective legislation, policies, and guidelines to prevent and respond to sexual violence and exploitation against children.

The CPWA is the basis for government responsibility to support an effective response to sexual violence and exploitation against children in Lesotho, yet many challenges remain to make it operational and linked to the service environment. PEPFAR/Lesotho should support the development of subsidiary regulations, a costed implementation plan, and clearer guidance on the child protection system. This includes identifying remaining gaps to support the translation and dissemination of the CPWA (which is currently under way) and supporting public education and sensitization for communities, families, and children on the child protection laws, in particular those that address sexual violence and exploitation (especially the key provisions noted in Box 3). Documents providing guidance of standard operating procedures are needed to help communities, providers, civil society, and the GOL understand national- and district-level responses and reporting procedures for ensuring child protection, including protection from sexual abuse. For each audience, the

guidelines should offer specific guidance on how to report, refer, and follow up cases and to articulate best practices for maximizing benefits to the child. These guidelines should include, at a minimum:

- *Definitions:* These are needed for all key players and their roles and responsibilities in the formal and informal systems (i.e., different ministries and GOL agencies, caregivers, chiefs, facilities, village councils, and other stakeholders), including the various institutional arrangements and linkages.
- *Reporting procedures:* These should specify the reporting options for families and children and make it clear that reporting to the police is not a prerequisite for obtaining medical care and that a child who has experienced sexual exploitation and violence should never be forced or pressured to report the sexual assault or undergo the medicolegal examination as a condition of receiving other essential care.
- *Services:* The core or minimum package of services for all settings and references to any supporting guidelines, such as clinical protocols for the facility level.
- *Required capacities and competencies:* These guidelines should also articulate the supporting capacities and competencies that need to be in place for these services to function sustainably, including the legal and normative framework (laws, policies, regulations, and standards); human and financial resources; management, coordination, and referral mechanisms; and monitoring and oversight.

The development of any guidelines must be done in consultation with civil society stakeholders, so that all parties who support PRC for children buy into the process. The process of developing guidelines will enable the GOL and stakeholders to communicate more effectively about the child protection system, support advocacy for strengthening the system, and help identify obstacles and opportunities in implementation, especially in reaching vulnerable or excluded groups.

Increase the evidence base on sexual violence against children.

Supporting prevalence studies, such as the Violence against Children Survey, will help mobilize action and track progress. Support for research should also include qualitative research to understand the circumstances surrounding violence; action research to identify cost-effective prevention interventions and care and support strategies (Together for Girls 2012); and continued analysis of sexual violence and exploitation data from the CGPU database, disaggregated by sex, age, and other factors, to provide updated information to government and development partners that can be used to raise awareness of the sexual abuse problem and help target budget allocations to the districts (UNICEF 2009).

Promote standardized facility care.

PEPFAR/Lesotho can support health systems strengthening by helping facilities to incorporate considerations of addressing sexual exploitation and violence against children within facility procedures and provider capacities. These critical actions should include:

- *Developing protocols for medical treatment:* PEPFAR/Lesotho can support the development, dissemination, and implementation of detailed clinical protocols outlining case management for health providers, including initial intake procedures, protocols for physical examination, legal documentation, and clinical management. Protocols, which can build on existing protocols for children as well as *The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs* (Day and Pierce-Weeks 2013), should include guidance on referral and follow-up to ensure that children continue to obtain care after leaving the facility. An easy-to-use format might incorporate a basic checklist function that takes into account providers' busy workloads.
- *Building medical providers' capacity (especially nurses):* All providers responsible for a child who has experienced sexual violence and exploitation should undergo basic sensitization training and orientation, specialized

training on medicolegal examination and HIVnPEP in the context of sexual violence and exploitation against children, and clinical and referral protocols, once these are developed. Training must cover providers' main roles—managing medical care for children who have been sexually abused and ensuring that children and their caregivers are aware of, appropriately referred to, and able to access additional support services. The training must also clarify providers' roles beyond the medical exam and referrals, such as any follow-up responsibilities once the child has left the facility. Training and systems-strengthening strategies should especially target nurses, who make up the largest cadre (73 percent) of health workers in Lesotho and are the primary providers addressing cases of sexual violence against children (Mwase et al. 2010). Over the long term, systems strengthening will need to encompass all nursing education by incorporating training on child sexual violence at all stages. In-service and refresher trainings are not sufficient to ensure high-quality, child-friendly services for these vulnerable children; training must begin at the pre-service stage.

Promote standardized facility-community linkages and follow-up care.

PEPFAR/Lesotho can support the MOSD to develop basic guidance for social workers who follow cases of sexual exploitation and violence against children, starting when a child is identified at a health facility and linked to a social worker and continuing with the social worker's responsibilities in the community. Guidance should include emergency counseling, long-term psychosocial support, referrals, and household visits and follow-up. Social workers should receive training on dealing with violence in the household, conflict resolution (given that many children return to households with the perpetrators still living there), and supporting children and their caregivers throughout the legal process. As part of this, PEPFAR/Lesotho could also promote the institution of mandatory training for social workers on sexual exploitation and violence against children, including roles and responsibilities and the importance of case management oversight at the district level. Any work with social workers should also include awareness raising on the particular needs of disabled children, the needs of families whose child has been abused, and the different issues that boys and girls may face.

Promote the establishment of a one-stop center.

PEPFAR/Lesotho should investigate supporting a one-stop center response model that offers a full range of essential care for children who have experienced sexual violence and exploitation. Nearly all respondents recommended establishing this type of center. However, there is debate in the larger child protection community about the efficacy of a one-stop center that should be considered. Because it would be challenging to make such a center cost effective and sustainable, placing it within an existing operating hospital that contributes space and resources, such as Queen Mamahato Hospital, would be a viable option. This would also reduce the stigma that might be associated with visiting a stand-alone center. Besides offering clinical services, the one-stop center should ideally incorporate: 1) CGPU officers to open dockets and take statements on-site, 2) social workers to provide case management and counseling support, and 3) lay counselors to provide crisis counseling and psychosocial support to the child and family. Funding permitting, this center could also engage a part-time individual to liaise with the prosecutor, monitor cases going to trial (coordinated via civil society groups), and refer children for additional services such as long-term psychological counseling, emergency shelter, or ART. Managers considering a one-stop center should contemplate additional factors, including:

- *Caveats:* The challenges the UN Fund for Population Activities (UNFPA) and the MOH faced with developing and operating the GBV One Stop Center in Lesotho, which has experienced numerous roadblocks.
- *Transportation:* The time and expense of travel, which constitute a major barrier to medical care throughout the developing world. However, there are innovative transport schemes that have been successful, such as reimbursing taxi drivers for transport expenses when they bring a child to the facility.

- *Outreach:* Part of this initiative must include sensitization with communities about the availability of this center, and highlight that this center is also sensitive to the needs of disabled children; as one respondent noted, “If the community is aware that decent services are available, this would increase reporting.”

Strengthen the capacity of civil society stakeholders.

Civil society, which is the backbone of any response to CSA, plays a tremendous role in promoting improved care for children who have experienced sexual violence and exploitation. PEPFAR/Lesotho is already supporting a number of civil society initiatives; however, there are signs that these efforts are disconnected and not coordinated in a way that maximizes efficiency. In parallel with work to coordinate the overall national response, PEPFAR/Lesotho could coordinate partners’ efforts to enhance children’s welfare, promote the tenets of the CPWA, and address gaps in the system. Key civil society activities should include:

- Supporting child rights advocacy to focus attention on the holistic wellbeing of the child (as compared with the current focus, which centers around legal justice for the perpetrator) and helping make the government, donors, and relevant agencies accountable for ensuring that the CPWA is implemented.
- Lobbying for specific changes to the system, such as pushing for health staff to prioritize CSA, promoting understanding of abuse as both a health issue and an HIV risk, expanding the provision of the medicolegal exam to include trained nurses, advocating for changes to the Sexual Offense Form so that nurses can legally sign it, and promoting the availability of the Sexual Offense Form at health facilities and with village chiefs.
- Raising community awareness of sexual violence and exploitation against children to build networks for child protection within the community. Reaching and empowering village leaders and VSGs are critical to achieving this. PEPFAR/Lesotho may need to formalize the existence of VSGs to strengthen their ability to fulfill their roles and responsibilities in child protection. Any work with VSGs should ensure that volunteers are not taking on too many tasks and should provide training (including leadership training) and systematically develop linkages between VSGs and the formal system.

Explore restorative justice options.

The CPWA, Part XIII, includes guidance on restorative justice. For example, it provides for a “Family Group Conference” convened by the chair of a Village Child Justice Committee to address children’s care and protection in abuse cases. However, the assessment team did not learn about the existence of any Village Child Justice Committees during its visit, so it is unclear if these committees are currently operating. Nevertheless, PEPFAR/Lesotho could conduct a small pilot program to promote restorative justice activities that help children and their caregivers address the trauma that arises from the abuse. Such an approach may be especially useful in situations where a case is brought to the chief, but the caregiver chooses to not pursue legal action. The pilot program would begin with a detailed assessment of existing restorative justice activities (assessing the prevalence and current operating capacity of Village Child Justice Committees) to inform the intervention, and then build on examples of global best practices.

Engage with the education sector.

This situation analysis did not explore responses to sexual exploitation and violence in the education sector. However, the limited research that is available suggests high levels of CSA in the school setting. Recognizing this, it should be understood that schools provide an opportunity and referral point for reaching vulnerable children. As a starting point, PEPFAR/Lesotho could support a review of what (if any) education teachers are receiving about sexual violence and exploitation against children and an analysis of how to best address this problem in the school setting.

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APPENDIX A

VISIT SCHEDULE AND INTERVIEWEES

Sunday, July 29 – Tuesday, July 31	Travel to Lesotho
Tuesday, July 31	<p>11:00 a.m. Meeting with USAID (Brenda Yamba, OVC and Community Based Care Specialist, USAID)</p> <p>2:00 p.m. Meeting with USAID, Pact, EGPAF and MSH Teams (Brenda Yamba, OVC and Community Based Care Specialist, USAID; Dr. Charles Ajayi, Care, Treatment and Support Specialist, USAID; Dr. Leopold Buhendwa, Country Director, EGPAF; Dr. Appolonaire Tiam, Technical Director/Director of Clinical Services, EGPAF; Dr. Oluwasanmi Akintade, Reproductive Health Director, EGPAF; Dr. Oyebola Oyebanji, Integrated PMTCT, Care and Treatment Advisor, EGPAF; Kholotsa Moejane, Country Director, Pact; Benjamin Kerchan, HIV and AIDS Technical Advisor, Pact; Megh Raj Jagriti, Senior Technical Advisor, MSH)</p>
Wednesday, August 1	<p>9:00 a.m. Briefing with USG Representatives (Brenda Yamba, OVC and Community Based Care Specialist; Dr. Charles Ajayi, Care, Treatment and Support Specialist; Lucille Bonaventure, PEPFAR Coordinator; Makojang Mahao, HIV/AIDS Prevention Specialist; Malerato Brown, DOD Program Manager; Whitney Gauthier, CDC Deputy Director; Dr. Yohannes Eshete, Lab and Blood Safety Advisor)</p> <p>11:00 a.m. Meeting with LENASO (Mamello Makoe, Executive Director; Tseluso Makoa, M&E Director; Mamokupo Tsephane, Finance Director)</p> <p>2:00 p.m. Meeting with Save the Children (Motselisi Shale, Program Manager; Lawrence Masupha, Social Worker)</p> <p>2:00 p.m. Meeting with Lesotho Child Counseling Unit (LCCU) (Lydia Musu, Founder and Executive Director)</p>
Thursday, August 2	<p>10:30 a.m. Meeting with Tsepong Counseling Center (Flory Kolobe, Mpho Ntsaba)</p> <p>12:00 p.m. Meeting with Lesotho Society of Mentally Handicapped Persons (LSMPH) (Kgomoco Motsamai, Director; Mafumane Makhele,</p>

	<p>Program Manager)</p> <p>2:00 p.m. Meeting with Baylor International Pediatric AIDS Initiative (Dr. Jill Sander, Associate Director; Leobohang Mpakanyane, Psychologist; Dr. Knowledge Chipango, Staff Medical Doctor)</p> <p>3:00 p.m. Meeting with Lesotho Federation of Women Lawyers (FIDA) (Tankiso Mophisi, Legal Aid Officer)</p>
Friday, August 3	<p>9:00 a.m. Meeting with UNFPA (Nestor Owomuhangi, International Programme Specialist; Thabelo Ramatlapeng, Reproductive Health Advisor)</p> <p>1:30 p.m. Meeting with Pact (Benjamin Kerchan, HIV/AIDS Technical Advisor)</p> <p>3:00 p.m. Meeting with Ministry of Social Development (Selloane Qhobela, Principal Secretary Social Welfare; Matebello Mantee, Senior Child Welfare Officer)</p>
Saturday, August 4	<p>Meeting with Lepoqong Village Support Group, Maputsoe, Leribe District</p> <p>Meeting with Loantsang Village Support Group, Maputsoe, Leribe District</p>
Sunday, August 5	<p>Travel to Thaba Tseka</p>
Monday, August 6	<p><i>In Thaba Tseka:</i></p> <p>9:00 a.m. Meeting with District Social Welfare team (and District Health Management Team (DHMT) members) (Horoto Horoto, Senior Child Welfare Officer; SehloMeng Tsiu, Rehabilitation Officer; Marooe Nnokoane, Child Welfare Officer)</p> <p>10:30 a.m. Meeting with Thaba Tseka Police Station, Child and Gender Protection Unit (CGPU) (Tsalong, Inspector; Nkomane, Police Constable, Tsuinyana, Police Constable; Leahna, Police Constable, Senkame, Student)</p> <p>12:30 p.m. Meeting with Nurses and Counselors at Parary Mission Hospital (Sr. Callixfina Maepa, Manager Hospital Nursing Services; Chabalala Mahewlo, ART Nurse; Tsunyane Papalo, Nurse Midwife; Polaki Mojeki, ART Nurse; Thabo Lejone, Solidadamed; Matumane Nchole, Nurse; Sefako Makosholo, Counselor; Mancheme Mokhethi, Counselor)</p> <p><i>In Maseru:</i></p> <p>8:00 a.m. Meeting with SWAALES (Thabang Malisa, Program Officer and Moeti Moleko, Program Coordinator)</p>

	<p>10:00 a.m. Meeting with Queen Mamamoto Hospital (Karen Prius, Executive Director; Makatleho Makatjane, Nurse Manager/Chief Nursing Officer; Dr. Unni Wariyar, Clinical Director)</p> <p>3:00 p.m. Meeting with Ministry of Gender (Mme Mathau, Director General; Thabang Malisa, Program Officer; Moeti Moleko, Program Coordinator)</p> <p>4:00 p.m. Meeting with Millennium Challenge Account/Lesotho (MCA) (Limphe Mawma, Gender Coordinator)</p>
Tuesday, August 7	<p>8:30 a.m. Meeting with CGPU Lesotho (Malebohang Nepo, Inspector; Manthethe Maemela, Inspector; Siphon Langelibalele Qhojeng; Detective Police Constable)</p> <p>11:00 a.m. Meeting with Catholic Commission for Justice and Peace (Booi Mohapi, Director; Mamotsiba, Makara, Gender and Children Program Coordinator)</p> <p>1:00 p.m. Meeting with EGPAF (Dr. Appolonaire Tiam, Technical Director/Director of Clinical Services)</p> <p>2:30 p.m. Meeting with UNICEF (Farida Nouredine, Child Protection Specialist/OVC; Blandinah Motaung, Health Officer/PMTCT; Makhetha Moshabesha, Youth and Adolescent Development Officer)</p> <p>4:00 p.m. Meeting with MSH (Megh Raj Jagriti, Senior Technical Advisor)</p>
Wednesday, August 8	<p>9:30 a.m. Meeting with Beautiful Gate (Brian Gearink, Director)</p>
Thursday, August 9	<p>11:00 a.m. Outbrief with USAID/Lesotho (Brenda Yamba, OVC and Community Based Care Specialist)</p> <p>2:00 p.m. Findings meeting Participants included:</p> <ul style="list-style-type: none"> • Tsaoarelo Linyai, Victims Advocate, Victims Office • Nthabising Molise, NEPI Coordinator, ICAP/MOH • Malebohang Nepo, Coordinator, CGPU • Siphon Qhojeng, Coordinator, CGPU • Brian Gearink, Director, Beautiful Dreams • Kholotsa Moejane, Country Director, Pact • Megh Raj Jagriti, Senior Technical Advisor, MSH • Brenda Yamba, OVC and Community Based Care Specialist, USAID • Benjamin Kerchan, HIV and AIDS Technical Advisor, Pact • Tankiso Mophisi, Legal Aid Officer, FIDA • Thabelo Ramatlapeng, Reproductive Health Advisor, UNFPA

	<ul style="list-style-type: none"> • Matebello Malite, Ministry of Social Development • Manthathi Phomane, Communications Manager, PSI • Ntolo Lekhotsa, OVC Coordinator, LENASO • Majimisi Madai, Peace Corps, HIV and AIDS Coordinator • Moelo Sehlabaka-Ramahlele, Mohlomi Hospital, Psychologist • Mamotsiba Makara, Gender Focal Person, CCJP • Booi Mohapi, Director, CCJP • Realeboha Shale, Quthing District Community Coordinator • Thabelo Ramatlapeng, UNFPA, Reproductive Health Advisor • Moeti Moheko, SWAALES, Program Coordinator • Mamello Makeac, Director, LENASO • Jill Sanders, Baylor, Clinical Director • Kaela Hardin, Program Coordinator, Beautiful Dreams • Karin Sandstram, Director, Beautiful Dreams • Lydia Muso, LCCU, Director <p>4:00 p.m. Meeting with Quthing District Coordinator, DCPT member. Realeboha Shale, Quthing District Community Coordinator</p>
Friday, August 10	Depart from Lesotho
Other Communications <i>(via email and phone interviews/exchange)</i>	International Center for AIDS Care and Treatment (ICAP) Partners in Health/Lesotho Beautiful Dreams/Lesotho

APPENDIX B

INTERVIEW GUIDE

Interview Questions			
	Providers	Community Stakeholders	Implementing Partners
I	General		
I.1	Please describe your role and what you do to support post-rape care for children in your institution?	Please describe your role and what you do in your community to support post-rape care for children in your community?	Please describe your role and what you do in your community to support post-rape care for children in your community?
I.2	<p>Think about an “exceptional” experience you have had that relates to addressing the needs of a child experiencing sexual violence. Please describe that experience to me.</p> <p>PROBE→ <i>what made it exceptional? what systems were in place, who was involved, etc.</i></p>	<p>Think about an “exceptional” experience you have had that relates to addressing the needs of a child experiencing sexual violence. Please describe that experience to me.</p> <p>PROBE→ <i>what made it exceptional? what systems were in place, who was involved, etc.</i></p>	<p>Think about an “exceptional” experience you have had that relates to addressing the needs of a child experiencing sexual violence. Please describe that experience to me.</p> <p>PROBE→ <i>what made it exceptional? what systems were in place, who was involved, etc.</i></p>
I.3	What do you value most about your work with children experiencing sexual violence?	What do you value most about your work with children experiencing sexual violence?	What do you value most about your work with children experiencing sexual violence?
I.4	Reflecting on your experience what do you see as the most significant issues regarding children protection in the community?	Reflecting on your experience what do you see as the most significant issues regarding children protection in the community?	Reflecting on your experience what do you see as the most significant issues regarding children protection in the community?

	<p>PROBE→</p> <ul style="list-style-type: none"> • For girls • For boys • For children of different ages 	<p>PROBE→</p> <ul style="list-style-type: none"> • For girls • For boys • For children of different ages 	<p>PROBE→</p> <ul style="list-style-type: none"> • For girls • For boys • For children of different ages
1.5	<p>Please describe other programs at the national and district levels that you are aware of that provide PRC for children.</p> <p>What other services do you know of in the community which support PRC for children once they return home? Please describe how these services work together.</p> <p><i>PROBE→ How are these services are directly linked to the health facility, and how? Please describe.</i></p>	<p>Please describe other programs at the national and district levels that you are aware of that provide PRC for children.</p> <p>What other services do you know of in the community which support PRC for children once they return home? Please describe how these services work together.</p> <p><i>PROBE→ How are these services are directly linked to the health facility, and how? Please describe.</i></p>	<p>Please describe other programs at the national and district levels that you are aware of that provide PRC for children.</p> <p>What other services do you know of in the community which support PRC for children? Please describe how these services work together.</p> <p><i>PROBE→ How are these services are directly linked to the health facility, and how? Please describe.</i></p>
1.6	<p>What do you perceive as the key role medical providers should play in providing PRC for children?</p> <p><i>PROBE→ How do you envision your role in PRC beyond medical/forensic? For example, do you see your role as linking to a) communities, b) legal, c) law enforcement, and d) judiciary? Please provide examples of each.</i></p>	<p>What do you perceive as the key role medical providers should play in providing PRC for children?</p>	<p>What do you perceive as the key role medical providers should play in providing PRC for children?</p>
1.7	<p>What do you perceive as the key roles communities should play in providing PRC for children?</p>	<p>What do you perceive as the key roles communities should play in providing PRC for children?</p>	<p>What do you perceive as the key roles communities should play in providing PRC for children?</p>
1.8	<p>In what ways are community stakeholders or supporters of children involved in thinking about how you provide care to these children? In what ways could they be engaged?</p>	<p>In what ways are community stakeholders or supporters of children involved in thinking about how facilities provide care to these children? In what ways could communities be engaged?</p>	<p>In what ways are community stakeholders or supporters of children involved in thinking about how facilities provide care to these children? In what ways could communities be engaged?</p>
1.9	<p>a. Are there conditions in the community that might be protective against sexual violence, especially for children? What can be built upon?</p> <p>b. Are there conditions in the community that might</p>	<p>a. Are there conditions in the community that might be protective against sexual violence, especially for children? What can be built upon?</p> <p>b. Are there conditions in the community that might</p>	<p>a. Are there conditions in the community that might be protective against sexual violence, especially for children? What can be built upon?</p> <p>b. Are there conditions in the community that</p>

	<p>promote sexual violence, especially for children?</p> <p>c. At the same time, are there situations or factors in the community that we can build upon to prevent gender based violence against children?</p>	<p>promote sexual violence, especially for children?</p> <p>c. At the same time, are there situations or factors in the community that we can build upon to prevent gender based violence against children?</p>	<p>might promote sexual violence, especially for children?</p> <p>c. At the same time, are there situations or factors in the community that we can build upon to prevent gender based violence against children?</p>
1.10	<p>a. Please describe how a child who has been sexually abused winds up at a health facility?</p> <p>b. What kind of information is available within the community about where to receive (facility-based) services for children who have been sexually abused?</p> <p>c. If a child is discovered to have been abused, what barriers would s/he faces in accessing facility based care?</p> <p>d. Why do you think some children are accessing services at a facility, and not others? What can be put in place to ensure more children who have experienced sexual violence receive care at a facility?</p>	<p>a. Please describe how a child who has been sexually abused winds up at a health facility?</p> <p>b. What kind of information is available within the community about where to receive (facility-based) services for children who have been sexually abused?</p> <p>c. If a child is discovered to have been abused, what barriers would s/he faces in accessing facility based care?</p> <p>d. Why do you think some children are accessing services at a facility, and not others? What can be put in place to ensure more children who have experienced sexual violence receive care at a facility?</p>	<p>a. Please describe how a child who has been sexually abused winds up at a health facility?</p> <p>b. What kind of information is available within the community about where to receive (facility-based) services for children who have been sexually abused?</p> <p>c. If a child is discovered to have been abused, what barriers would s/he faces in accessing facility based care?</p> <p>d. Why do you think some children are accessing services at a facility, and not others? What can be put in place to ensure more children who have experienced sexual violence receive care at a facility?</p>
2	Case Management and Systems (Facility Level)—Now we would like more detail on the facility-based part of providing PRC for children		
2.1	<p>a. Please describe the staffing structure and roles/responsibilities at your facility in terms of providing PRC for children.</p>		
2.2	<p>a. In your practice, what happens when a child presents with signs of abuse? Are they seen immediately? Who sees them? Are they seen in a private space?</p> <p>b. What guidelines for PRC for children exist? Are they specific to children or contain guidance for addressing the specific needs of children? What are they? <i>(ask for a copy, to be compared against Technical Considerations, Box 2, Standards of Care)</i></p>		<p>a. In your experience, what happens when a child presents with signs of abuse?</p> <p>b. What guidelines for PRC for children exist? What are they? <i>(ask for a copy)</i></p>

2.3	<p>a. What institutional mechanisms or systems are in place and work consistently that ensure children receive <i>immediate</i>:</p> <ul style="list-style-type: none"> • emergency medical care? • emotional and psycho-social care? • legal services and representation? • safe family care placement when needed? <p>b. What specific gaps in immediate care need to be addressed, and how?</p>	<p>a. What institutional mechanisms or systems are in place and work consistently that ensure children receive <i>immediate</i>:</p> <ul style="list-style-type: none"> • emergency medical care? • emotional and psycho-social care? • legal services and representation? • safe family care placement when needed? <p>b. What specific gaps in immediate care need to be addressed, and how?</p>	<p>a. What institutional mechanisms or systems are in place and work consistently that ensure children receive <i>immediate</i>:</p> <ul style="list-style-type: none"> • emergency medical care? • emotional and psycho-social care? • legal services and representation? • safe family care placement when needed? <p>b. What specific gaps in immediate care need to be addressed, and how?</p>
2.4	<p>a. From your perspective, what is working well in facility-based case mgt of children experiencing sexual violence?</p> <p>b. What could be improved?</p>	<p>a. What is working well in facility-based case mgt?</p> <p>b. What could be improved?</p>	<p>a. What is working well in facility-based case mgt?</p> <p>b. What could be improved?</p>
2.5	Describe the referral system for social/legal services for children who have faced sexual violence. How well do referrals works across the systems to ensure children receive follow-up care? (once they leave the facility)	Describe the referral system for social/legal services for children who have faced sexual violence. How well do referrals works across the systems to ensure children receive follow-up care? (once they leave the facility)	Describe the referral system for social/legal services for children who have faced sexual violence. How well do referrals works across the systems to ensure children receive follow-up care? (once they leave the facility)
3 Case Management and Systems (Community Level)—what happens when a child returns to community			
3.1	<p>a. What current activities/services /structures support families/children once they transition back to the community? Examples?</p> <ul style="list-style-type: none"> • What are the existing social service services (i.e., to help children manage the psycho-social impacts of violence, reintegrate back into households, etc.?) • What are the existing legal services? <p>b. How are these linked to the provision of post rape care in the health facility setting? Examples?</p>	<p>a. What current activities/services /structures support families/children once they transition back to the community? Examples?</p> <ul style="list-style-type: none"> • What are the existing social service services (i.e., to help children manage the psycho-social impacts of violence, reintegrate back into households, etc.?) • What are the existing legal services? <p>b. How are these linked to the provision of post rape care in the health facility setting? Examples?</p>	<p>a. What current activities/services /structures support families/children once they transition back to the community? Examples?</p> <ul style="list-style-type: none"> • What are the existing social service services (i.e., to help children manage the psycho-social impacts of violence, reintegrate back into households, etc.?) • What are the existing legal services? <p>b. How are these linked to the provision of post rape care in the health facility setting? Examples?</p>

3.2	<p>From your perspective, what are these community structures doing well to support post rape care for children, and what could they be doing better? Please describe.</p> <p>PROBE→ <i>What can we build upon to promote the care a child when he/she returns to the community after experiencing sexual violence and seeking care? Please describe.</i></p>	<p>From your perspective, what are these community structures doing well to support post rape care for children, and what could they be doing better?</p> <p>PROBE→ <i>What can we build upon to promote the care a child when he/she returns to the community after experiencing sexual violence and seeking care? Please describe.</i></p>	<p>From your perspective, what are these community structures doing well to support post rape care for children, and what could they be doing better? Please describe.</p> <p>PROBE→ <i>What can we build upon to promote the care a child when he/she returns to the community after experiencing sexual violence and seeking care? Please describe.</i></p>
3.3	<p>If you were granted 3 wishes to improve clinical services for children who experience violence, what would they be?</p> <p>If you were granted 3 wishes to improve linkages between community services and facility services for children who experience violence, what would they be?</p>	<p>If you were granted 3 wishes to improve community services for children who experience violence, what would they be?</p> <p>If you were granted 3 wishes to improve linkages between community services and facility services for children who experience violence, what would they be?</p>	<p>If you were granted 3 wishes to improve services for children who experience violence, what would they be?</p> <p>If you were granted 3 wishes to improve linkages between community services and facility services for children who experience violence, what would they be?</p>
3.4	<p>Is there anything else you would like to tell me that you didn't because I did not ask the right question? Or any other insights or comments you would like to make?</p> <p>Any questions for me?</p>	<p>Is there anything else you would like to tell me that you didn't because I did not ask the right question? Or any other insights or comments you would like to make?</p> <p>Any questions for me?</p>	<p>Is there anything else you would like to tell me that you didn't because I did not ask the right question? Or any other insights or comments you would like to make?</p> <p>Any questions for me?</p>
4 OPTIONAL			
4.1	<p>What terminology do you use for child sexual abuse/assault/rape/violence?</p>	<p>What terminology do you use for child sexual abuse/assault/rape/violence?</p>	<p>What terminology do you use for child sexual abuse/assault/rape/violence?</p>

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

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