LESSONS LEARNED IN PROVIDING SGBV SERVICES IN AFRICA

A REVIEW OF EMERGING EVIDENCE
Background

- Services to meet the needs of survivors are weak
  - Limited public awareness, social stigma
  - Lack of documented experiences with what works
  - Focus on prosecuting the perpetrator, rather than caring for the survivor

- Needs of survivors vary greatly depending on:
  - Female, male
  - Adult, adolescent, child
  - Nature of assault
  - Disease epidemiology
  - Legal options available
  - Socio-cultural context
How to organize responsive services – especially for sexual assault?

Most African countries characterized by

- *no* dedicated medico-legal services …
- or by poorly organized and separate services
Which services could – or should – be included in a comprehensive response?

**Medical**
- Management of sexual violence at 1st point of contact with the survivor.
- Sensitive approaches to managing child survivors of sexual violence, and encouraging and enabling presentation by male survivors.
- Screening for signs and symptoms of violence during routine health consultations.

**Justice System**
- Collection of forensic evidence and creation of a chain of evidence that can be used during prosecution.
- Strong links between medical and police facilities to enable incidents to be referred in either direction.

**Community**
- Psychological counselling.
- New or strengthened community-based prevention strategies that are relevant and appropriate for the local context.
- Physical, psychological, and emotional violence between domestic or intimate partners addressed through messages communicated during the prevention strategies.
The African regional SGBV network

- 9 countries
- 20+ partners

Supported by:

- Swedish-Norwegian HIV/AIDS Team
- OGAC - PEPFAR
- USAID - PEPFAR
- CIDA - GESP
Objectives of the SGBV network

- **Pilot** innovative approaches to SGBV service strengthening
- **Document** the feasibility of these approaches
- **Promote** evidence-based policies and programs across the region
Lessons Learned
Lesson 1

Legislation and policies, guidelines, protocols, and validated training curricula are **necessary, but not sufficient** for ensuring coordinated responses to SGBV.
Necessary, but not sufficient

- In many countries, existing guidelines are un- or under-utilized
  - Uganda, Malawi, South Africa

- In many more, guidelines being currently developed through multisectoral processes
  - Will this improve implementation?
“One stop shops” are not the only—or the ideal—model for delivering SGBV services.
What do we mean by “one-stop”?

- Centralizing all clinical services in one facility
  - Evidence demonstrate improved health service delivery

vs.

- Centralizing police, legal and medical services in one (stand alone) facility
  - No evidence on appropriateness or cost-efficacy
Alternate models

- Integrated care within existing health facilities, linking to police (Malawi)

- Strengthening police services and linkages to health centers (Zambia)

- Victim advocate, or “buddy system” where integrated services not available (South Africa)
Lesson 3

Majority of survivors reporting sexual assault are children or adolescents...yet services are commonly designed for adult women
Majority of Reported Cases are Children (Zambia 2006-2008)
Majority of **Reported** Cases are Children
(Kenya, 2003-2004; MOH, LVCT Data)

![Bar chart showing age distribution of reported cases](chart.png)
High numbers of male survivors in Mombasa, Kenya
August 2007 - May 2009

Source: International Center for Reproductive Health- Kenya
DV more prevalent than SV

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<th>Country</th>
<th>Source</th>
<th>Ever experienced physical violence (all women)</th>
<th>Ever experienced sexual violence (all women)</th>
<th>HIV Prevalence (male and female)</th>
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Lesson 4

Medico-legal procedures can serve as a barrier to accessing medical and other management services.
Legal barriers to health care

Among the public:
- Limited (or incorrect) awareness of requirements for receiving care
- Unwillingness to prosecute family members
- Police most often first— and only— point of contact

Among care providers:
- Limited (or incorrect) awareness of requirements for delivering care
- Limited awareness of forensic evidence collection and procedures
- Unwillingness/ Inability of health workers to present evidence
Lesson 5

Very little is known about:

a) addressing the immediate and long-term psychosocial needs of survivors in Africa

b) the feasibility, safety and effectiveness of addressing IPV / DV within low-resource health services
Concluding messages

✓ Increased realization of prevalence and seriousness of SV in general populations

✓ Current and desired service responses poorly understood

✓ Need for strategic and coherent programme of action to stimulate national responses