Welcome to the 2013 Meeting of the Africa Regional SGBV Network

Wednesday, December 4, 2013
District Architecture Center
Washington, DC
About the Africa Regional SGBV Network

Since 2006, the Council has led the *Africa Regional SGBV Network* in the design, implementation, evaluation, and scale-up of interventions that involve multiple actors (e.g., education, police, and health providers).

• The project responds to SGBV by:
  
  • Testing and documenting best practices from SGBV services;
  • Providing technical assistance through our partners; and
  • Influencing policy/programs by sharing best practices
Today’s Objective

Share research and best practices from country-level initiatives that have informed the development of policies and programs that respond to the needs of survivors and help prevent violence from occurring.
# Today’s Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Presentation</th>
<th>Presented By</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 AM – 9:00 AM</td>
<td>Breakfast</td>
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<tr>
<td>9:00 AM – 9:10 AM</td>
<td>Opening Remarks</td>
<td>Ian Askew, Chi-Chi Undie</td>
</tr>
<tr>
<td>9:10 AM – 9:25 AM</td>
<td><strong>Presentation #1</strong>: Gender-Based Violence Recovery Centre, Kenyatta National Hospital, Kenya</td>
<td>Margaret Mak’anyego and Chi-Chi Undie</td>
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<tr>
<td>9:25 AM – 9:40 AM</td>
<td><strong>Presentation #2</strong>: Liverpool VCT, Care and Treatment, Kenya</td>
<td>Carol Ajema</td>
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<tr>
<td>9:40 AM – 10:00 AM</td>
<td>First Round of Open Discussion/Q&amp;A</td>
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<tr>
<td>10:00 AM – 10:15 AM</td>
<td><strong>Presentation #3</strong>: Thohoyandou Victim Empowerment Programme, South Africa</td>
<td>Craig Carty and Thandi Hadebe</td>
</tr>
<tr>
<td>10:15 AM – 10:30 AM</td>
<td><strong>Presentation #4</strong>: Swaziland Action Group Against Abuse, Swaziland</td>
<td>Cebile Manzini-Henwood</td>
</tr>
<tr>
<td>10:30 AM – 10:45 AM</td>
<td><strong>Presentation #5</strong>: Zambia Police Service, Zambia</td>
<td>Joseph Manzi Shanampota, Mary Zama, and Jessica Price</td>
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<tr>
<td>10:45 AM – 11:05 AM</td>
<td>Second Round of Open Discussion/Q&amp;A</td>
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<tr>
<td>11:05 AM – 11:10 AM</td>
<td>Closing Remarks</td>
<td>Ian Askew</td>
</tr>
<tr>
<td>11:10 AM – 11:30 AM</td>
<td>Open Marketplace</td>
<td>All</td>
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</table>
Feasibility of Routine Screening for Intimate Partner Violence (IPV) in Public Health Care Settings in Kenya

Margaret Mak’anyengo
Chi-Chi Undie
Catherine Maternowska
Ian Askew
Mission: To provide comprehensive, accessible, quality care to survivors; enhance advocacy; provide training and research; and participate in national planning and policy in relation to GBV issues
Key Take-Away Messages

• Routine screening for IPV ...
  ✓ Is feasible in low-resource settings
  ✓ Key populations of interest include youth and HIV+ clients
  ✓ Has implications for male involvement in women’s health care
  ✓ While feasible, should not be conducted everywhere

• Engaging with regional and international bodies can help broaden reach of SGBV efforts
Background

- **Most common form of violence** against women worldwide

- **Africa**: One of the regions in which lifetime physical and/or sexual IPV prevalence is highest (37%)

- **Kenya**: About half (47%) of ever-married women have experienced some kind of IPV (physical, sexual, or emotional) – mostly recent (in the last 12 months)
To Screen or Not to Screen?

Potentially beneficial, but presumed barriers in developing countries …

- Sociocultural barriers to disclosure
- Provider capacity
- Weak referral systems and linkages
- Confidentiality issues
- Inadequate follow-up care after screening
Intervention Involved Three Main Activities

- **Provider training** to routinely screen for IPV (April-May 2012)
- **Routine screening** for IPV by providers (June-December 2012)
- **Provider referral** of IPV+ clients to the GBVRC for further care (June-Dec. 2012)
Study Design

- Qualitative, multi-site case study (ANC, CCC, Youth Centre at KNH)
  - Four FGDs with 23 providers
  - IDIs with clients
    - 36 ‘compliant’ clients
    - 29 ‘non-compliant’ clients
  - Collation of service statistics
Key Findings

- **Over a third (38%)** of IPV+ clients identified were youth (18-24 years).
- HIV+ clients **most likely to be IPV+ and** to be experiencing composite violence.
- Sexual IPV more likely to be reported **by young people**.
- But **psychological violence** most commonly-reported form of IPV overall.
# Key Findings

## Screening Statistics for Initiating Departments Combined

<table>
<thead>
<tr>
<th>Total # screened &amp; documented</th>
<th>% reporting IPV (n=95)</th>
<th>% referred to GBVRC (n=73)</th>
<th>% presenting at GBVRC (n=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,210</td>
<td>8%</td>
<td>77%</td>
<td>40%</td>
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</table>
### Next Steps

**Policy**

| Population Council & KNH working with ECSA-HC to help operationalize via development of **IPV screening training manual** for the region |
| Resolution on GBV and CSA screening passed by **Health Ministers** in East, Central and Southern Africa region in response to study findings (Dec. 2012) |
Next Steps

Programming

Screening

- WHO Handbook
- KNH
- Other health contexts
- Humanitarian settings
- Children
Next Steps

Funding


Sweden, Norad: Potential for Phase III funding (children, etc.) (2014-2016)
Thank You!
Improving the Collection, Documentation and Utilisation of Medico-Legal Evidence in Kenya

Carol Ajema, Wanjiru Mukoma
Liverpool VCT, Care and Treatment (LVCT)
LVCT is....

- An indigenous Kenyan organization
- Registered in 2001
- 240 staff covering 4 regions in Kenya

**Our Vision**
- Empowered, healthy communities

**Our Mission**
- To excel in HIV testing and counseling
- Use research results, capacity improvement and policy reform action to promote universal access to equitable HIV and SRH services reaching the most vulnerable populations
# How We Work

## The Services We Deliver
- GBV prevention and post-rape care
- Quality HIV testing and counselling
- Comprehensive & integrated HIV/TB care, ART, SRH, counselling services
- Combination HIV (evidence based behavioural, biomedical, structural) prevention

## Our Approach to Service Delivery/Programming
- LVCT Hatua: research-policy-practice cycle
  - Implementation research
  - Technical support to government
  - Policy advocacy
- Training & Capacity building:
  - Providers
  - Local CSOs
- Continuum of care:
  - Quality, integrated services
  - Effective linkage & retention in health care

## Outcomes
- Coverage, uptake of SRH, GBV services
- Capacity building
- Sustained HIV prevention for those HIV-ve
- Retain & viral suppression for HIV+ve
• **Rape kit utilisation** combined with joint provider training (police + health) improves the **collection, documentation, and use of medico-legal evidence** for survivors of sexual violence

• Working within **government structures** can help ensure institutionalisation of sexual violence efforts
# How We Got Here

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
<th>Issue</th>
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<tbody>
<tr>
<td>PRC1: 2004-06</td>
<td>Ops research: integrated PRC service &amp; uptake</td>
<td>Lack of awareness on services to be offered</td>
</tr>
<tr>
<td>PRC costing 2006</td>
<td>costs of scale up of services</td>
<td>Need for scale up of services</td>
</tr>
<tr>
<td>COE1: 2007-08</td>
<td>design, test model for a chain of evidence</td>
<td>Poor medico-legal linkages; no standards &amp; chain of evidence</td>
</tr>
<tr>
<td>COE2: 2010-12</td>
<td>evaluate PRC kit</td>
<td>Effectiveness of PRC kit for improved justice outcomes unknown</td>
</tr>
<tr>
<td>2006</td>
<td>National guidelines, training curricular; MOH 263 (PRC) medico-legal form</td>
<td></td>
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<tr>
<td>2007</td>
<td>Scale up plan with PRC indicators in DRH business plan</td>
<td></td>
</tr>
<tr>
<td>2009/10</td>
<td>Review of guidelines (stronger medico-legal section)</td>
<td></td>
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<tr>
<td>2011-13</td>
<td>Aim to strengthen medico-legal framework</td>
<td>Service linkages poor</td>
</tr>
<tr>
<td>PRC/PEP: 2011 – 14</td>
<td>in-planning- QA for PRC &amp; cohort f/u through CBS</td>
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</table>
• Developing a locally-assembled rape kit

• Training police and health providers on use of existing national protocols for documenting obtained evidence

• Data: Hospital and police records on sexual violence survivors
Findings

• **Evidence collection**: General improvement in intervention site compared to decline in comparison area

• **Provider completion of PRC forms**: Statistically significant diff btw intervention and comparison (Chi square 16.45, p=0.000; 95% CI)

• **Provider completion of P3 forms** at both police station and health facility: intervention site providers 3x as likely to have this done
Outcomes

• National guidelines and **documentation protocols revised** to include:
  - Chapter on forensic evidence management
  - IECs developed as part of the study
  - Rape kit content list

• Study’s **multi-sectoral training approach** adapted by Kenya’s Sexual Offences Implementation Taskforce, targeting:
  - Community opinion leaders
  - Police
  - Health care providers
Going Forward

• Documentary on evidence collection
  ➢ Teaching aid (advocacy for it to be included into national training curricula)

• Engagement in national processes towards implementation of a multi-sectoral referral network for:
  ➢ Survivors and
  ➢ Evidence collected
• What are the **justice outcomes** that can be linked to the utilisation of the PRC form?
  - Number of cases with positive legal outcomes based on evidence contained in the PRC form

• **Level of utilisation of PRC forms** in public health facilities
Building Partnerships, Transforming Lives

cajema@lvct.org
enquiries@lvct.org

www.liverpoolvct.org
one2onekenya.org
The Thohoyandou Victim Empowerment Programme (TVEP)

“There’s No Excuse For Abuse!”

To generate an attitude of ZERO TOLERANCE towards all forms of sexual assault, domestic violence, child abuse and HIV and AIDS stigmatization in the Thulamela Municipality (Vhembe District)

Craig Carty
VHEMBE DISTRICT: CONTEXT

POPULATION: 618,462 (Census, 2011)

HIV PREVALENCE: 21.5% (Vhembe District Department of Health, 2013)

UNEMPLOYMENT: 26.8% (Department of Labour, 2011)

1 REGIONAL & 2 DISTRICT HOSPITALS; 48 CLINICS; 3 HEALTH CENTRES

56% OF POPULATION UNDER 18 YEARS OLD

MALE: FEMALE RATIO: 45.1% to 54.9%

LIMPOPO PROVINCE UNDER “CENTRAL ADMINISTRATION” DUE TO FUNDING MISMANAGEMENT

REGION OF TRADITIONAL, PATRIARCHAL LEADERSHIP: CHIEFS AND KINGS

DIFFERING INTERPRETATIONS OF TRADITIONAL IDEOLOGIES

POLICE INCENTIVIZED TO REDUCE CRIME STATS = NON REPORTING

7 POLICE STATIONS
<table>
<thead>
<tr>
<th>Community Engagement &amp; Partnership-Building</th>
<th>Rights-Based Knowledge &amp; Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity &amp; Agency To Exercise Rights</td>
<td>Help-Seeking Behaviours, Access To Treatment &amp; Justice</td>
</tr>
<tr>
<td>Creation Of Safer Environments Directly Owing To Stakeholders</td>
<td>Pride, Community Ownership &amp; Sustainability</td>
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**Core Support Model**
ZTVA OUTPUTS AND OUTCOMES: 2011 - 2013

- 5,251 participants directly reached by ZTVA workshops (3 sites)
- Increased knowledge across thematic areas of focus (1,180 surveyed, 2 sites)
- Increases in SGBV and/or child abuse reporting during intervention period
- Even greater increases in SGBV reporting following oath-taking ceremony
- Ultimate decline in SGBV 12-months post (2 sites, FGD supported)

EVIDENCE (CI 95%, p <0.0001)

- Knows HIV status:
  - F \(\uparrow\) 25.2 - 27.6%
  - M \(\uparrow\) 24.6 - 32.8%
- Understanding of PEP importance:
  - F \(\uparrow\) 18.5 - 36.1%
  - M \(\uparrow\) 20.4 - 36.7%
- Knows how to access SGBV services:
  - F \(\uparrow\) 79.5 - 83.1%
  - M \(\uparrow\) 79.8 - 91.1%
The TVEP Support Model

- Evidence-Based Programming
- Best Methods Practices
- Partnership-Building
- Self-Sustaining
- Ease of Replication
- Scalability
- Cost Effectiveness
- Outcomes & Outputs to Inform Policy
- Zero Tolerance Village Alliance

24/7 “One Stop” Trauma Centres
15 Community “Help Desks”
24/7 Short-Term Shelters
Access to Justice
Community Outreach
Research & Advocacy
Monitoring & Evaluation
Community Empowerment
HIV/AIDS Services

Welcome to Mangondi: A Proud Member of the ZERO TOLERANCE VILLAGE ALLIANCE
ZTVA IMPLEMENTATION

- Site Selection
- ZTVA Awareness Campaign
- Stakeholder Forum Nominations
- Site Mapping
- MoA
- Community Activist Recruitment & Training
- ZTVA Launch
- Monitoring and Technical Assistance
- ZTVA Oath-Taking Ceremony
- Focus Group Discussions
- Evaluation
- Enhancements
- On-going Support from TVEP
- ZTVA stakeholders become the experts
**MEASURED REPORTING INCREASES**

- **SITE 1:**
  - 3.3 - FOLD INCREASE IN REPORTING DURING ZTVA INTERVENTION
  - 3.6 - FOLD INCREASE IN REPORTING 3 MONTHS POST-OATH CEREMONY
  - 11.84 - 13.02 - FOLD INCREASES VERSUS REGIONAL AVERAGES

- **SITE 2:**
  - 3.69 - FOLD INCREASE IN REPORTING DURING ZTVA INTERVENTION
  - 4.92 - FOLD INCREASE IN REPORTING 3 MONTHS POST-OATH CEREMONY
  - 7.25 - 9.68 - FOLD INCREASES VERSUS REGIONAL AVERAGES
**ACHIEVEMENTS & GOALS**

**GOALS OUTLINED FOR 2013**

- Initiate “Young Perpetrator Programme”
- Upscale child services enhancement programme and provision of “Healing Therapy” for child witnesses to violence
- Create electronic “ZTVA Toolkit” for ease of dissemination
- Identify partners to expand ZTVA to neighbouring provinces and countries in 2014
- Sustain Core Support Programming through Public-Private-CBO sector cost-sharing partnerships
- Write up additional ZTVA and TVEP successes for dissemination to public domain

**GOALS 2014 +**

- Conduct RCT using early childhood development, schools programmes and ZTVA to measure impacts on larger scale
- Compare Thuthuzela Care Centre model to TVEP CC model to inform future policy with DoSD and DoH
- Advocate for Emergency Contraception accessibility at initial points of SV reporting and in different settings
- Reinstate Female Condom advocacy & programming
- Introduce GLBTI programs
- Enhance the capacity and reach of the Vhembe Civil Society Network
- Finalize HWSETA accreditation for VEP training programmes
- Identify core support partners!
Special Thanks to the TVEP Staff & Volunteers, Project Participants, Village Leaders, Fiona Nicholson and All TVEP Funding Partners

FOR ADDITIONAL DOCUMENTS AND E-TOOLKIT INFORMATION, EMAIL:

THANDI@TVEP.ORG.ZA
CRAIG@TVEP.ORG.ZA

OR VISIT

www.tvep.org.za
National Guidelines for a Multisectoral Response to SGBV for Adults and Children in Swaziland

Cebile Manzini-Henwood
Swaziland Action Group Against Abuse (SWAGAA)
Context At-a-Glance

- Population approx 1 million
- Acute patriarchy and gender inequality
- Dual legal system
- By 2007, 26% of people aged 15-49 yrs were living with HIV
- 1 in 3 girls (13-24) had experienced some form of sexual violence (UNICEF-CDC, 2007)
Focus of the Swaziland Action Group Against Abuse

- Prevention
- Care and Support
- Access to Justice
- Institutional Development

**Prevention:**
Testing the feasibility and effectiveness of a comprehensive SGBV prevention project for in-school girls in Swaziland

**Care and Support for Survivors AND Access to Justice:**
Development of National Multisectoral Guidelines for Management of Sexual Violence Cases
Key Take-Away Messages

• The *process* of developing guidelines is in itself critical because it:
  
  o Fosters a *multi-sectoral approach* from the start; and
  
  o *Creates efficiencies and synergies* well in advance among various sectors contributing to the *care of survivors*
State of the SGBV Response in Swaziland

- No national multi-sectoral coordinating entity for SGBV prevention and response in Swaziland

- Response largely NGO-led (SWAGAA)

- Fragmented approach to management of survivors
  - No institutional memory

- Poor referral systems; no tracking tools

- Glaring need for continuum of care for survivors from point of reporting
The Project

SWAGAA is recognised as the country’s leading prevention, response and advocacy organization

**Purpose**: Development of **national guidelines** for a multi-sectoral response to SGBV for **adults and children in Swaziland**

- Through Sweden, Norad and Population Council support
- First ever for Swaziland
- SWAGAA spearheading development of National Multisectoral Guidelines for Management of Sexual Violence Cases
The Process

✓ Commitment secured from the Deputy Prime Minister’s Office

✓ Core Team established from broader network of response/referral partners
  ▪ Police, Health, Prosecution, Social Welfare, Ministry of Education, NGOs (2)

✓ Working meetings held for drawing on existing tools, manuals, practices within each sector

✓ Sector-specific responses consolidated by a Consultant

✓ Wider, sector-based consultations held
Outcomes

- Enhanced understanding of the need for coordination (by an agency) and monitoring
- Platform created for sharing challenges and communicating bottlenecks – creating sense of responsibility
- Increased inter-sectoral collaboration and communication
- Strengthened relationships among sectors and collaboration in advocating for law reform (e.g. Anti Sexual Offences law, Child Protection law)
- Platform provided for SWAGAA to facilitate increased understanding of survivor needs and for right to survivor-friendly services
Opportunities

- **New Gender Unit Director** committed to finalization and launching the guidelines
  - *To be included in the Unit’s 2014 Action Plan*

- Development of **National Strategic Framework** now underway in Swaziland
  - *Guidelines already viewed as a critical tool for facilitating implementation of this framework*

- Stakeholders calling for **finalization of the process**
  - *Demand has been created! Indication of commitment*

- Guidelines to be used as a **framework to guide SGBV referral partner meetings** and capacity-building
Opportunities (Cont’d)

• **Dissemination:**
  • Other key networks (e.g., National GBV Surveillance Network)
  • Training of service providers on the sector based responsibilities
  • Produce information materials for survivors to know what to expect from service providers

• **A tool for increasing accountability** among partners
Ode to the Africa Regional SGBV Network

- SGBV is one of the most pervasive social challenges being faced by our region
- **Concerted, individual efforts** at country level are not enough
- Network presents opportunity for **learning and sharing best practices**
- SWAGAA learnt about multisectoral guidelines through network and adopted **Zambia and Kenya** documents
Mitigating the Consequences of Sexual Violence by Decentralizing Emergency Medical Responses

Feasibility Study on Police Provision of Post-Exposure Prophylaxis for HIV (PEP) in Zambia

J. Shanampota (Zambia National Police)
M. Zama (Population Council)
J. Price (Population Council)
On-going

2012

National GBV Guidelines

2011

Anti-GBV Act

2005

Gender in Development Div

1994

Victim Support Units

Pre-Independence Law against SV

Anti-Gender-Based Violence [No. 1 of 2011]

ARRANGEMENT OF SECTIONS

PART I
PRELIMINARY

PART II
DEALING OF, AND DEALING WITH, COMPLAINTS OF GENDER-BASED VIOLENCE

PART III
PROTECTION ORDERS

PART IV
SHELTER FOR VICTIMS
# Feasibility Studies of Police Provision of Emergency Medical Interventions

<table>
<thead>
<tr>
<th>Avoiding pregnancy</th>
<th>Reducing HIV acquisition</th>
</tr>
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<tbody>
<tr>
<td>Emergency Contraceptive Pill (ECP)</td>
<td>Post-Exposure Prophylaxis (PEP)</td>
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</table>

- **Avoiding pregnancy**
  - Effective when provided within 120 hours of exposure

- **Reducing HIV acquisition**
  - Effective when provided within 72 hours of exposure

Police delivery of ECP proved feasible in a 2005 to 2008 study. Feasibility of policy delivery of PEP under study: 2011 to 2013. Included in national service guidelines. Feasible, but broader work—beyond official policy— is needed to have impact.
PEP Study Process with Victim Support Units (VSUs) in Two Lusaka Neighborhoods (est pop: ≈296,000)

**Formative Assessment**
- Interviews
- Observations
- Advocacy

- ≥10 years old
- Within 72 hours
- Not on HAART

**Intervention**
- Enabling VSUs to provide PEP
- Fostering community-VSU linkages
- Delivering PEP to eligible survivors
- Routine data capture

**Endpoint Interviews**
- Survivors
- Police
- Health workers
- Policy makers

2010-2011
2011-2013
2013
Survivors from Study Districts Reporting to VSUs and to UTH

<table>
<thead>
<tr>
<th></th>
<th>Participating VSUs</th>
<th>University Teaching Hosp (UTH)**</th>
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<tbody>
<tr>
<td><strong>Data extracted:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/12 – 10/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total cases reported</strong></td>
<td>207</td>
<td>156</td>
</tr>
<tr>
<td>Female</td>
<td>100%</td>
<td>99%</td>
</tr>
<tr>
<td><strong>Age (average)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10</td>
<td>47 (23%)</td>
<td>12 (8%)</td>
</tr>
<tr>
<td>10-16</td>
<td>129 (62%)</td>
<td>88 (56%)</td>
</tr>
<tr>
<td>17-24</td>
<td>15 (7%)</td>
<td>31 (20%)</td>
</tr>
<tr>
<td>≥25</td>
<td>16 (8%)</td>
<td>25 (16%)</td>
</tr>
<tr>
<td><strong>First reported to police</strong></td>
<td>97%</td>
<td>62%</td>
</tr>
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** Survivors at UTH enter through various clinics and are referred to gynecology or pediatric ward
SV Reporting at VSUs & UTH from Study Districts: Is There a Trend?
PEP Eligibility & Provision

- **Within 72 hours**
  - Eligible ≥10 years: n=104
    - Received PEP: n=26
    - Did not receive PEP: n=78
  - Not eligible <10 years: n=31

- **After 72 hours**
  - Eligible ≥10 years: n=135
  - Not eligible <10 years: n=72

(Data from Nov 1, 2012 to Oct 30, 2013)
Why Eligible Survivors Do Not Receive PEP at VSUs

- VSU officers not at the station or not on duty
  
  (53% of cases reported evenings or weekends)

- The survivor may be on HAART

- Survivors (and/or relatives) refuse PEP

- Case did not involve penetrative sex

- We just don’t know . . .
Decentralized PEP (and ECP) provision is **feasible**, but will have limited **impact** without broad social engagement, cross-sector linkages, and systems strengthening

One overall conclusion
Police Services

- Norm change – thru values clarification & accountability systems
- ECP & PEP delivery – decentralize to primary health centers and expand to all VSUs
- Reward service delivery & referrals – e.g., performance-based payments

Health System

- Norm change – thru public education, improved media coverage & advocacy
- ECP & PEP delivery – decentralize to community settings
- Reward service delivery & referrals – e.g., performance-based payments

(introduce SV case managers)
We Sincerely Thank . . .

- The National Zambian Police
- The Swedish government through SIDA
- NORAD
- The Zambian Ministry of Health
- The Zambian Ministry of Community Development
- Mother Child Health
- Intervention communities
- Survivors of sexual violence included in this study
Concluding Remarks
Thank You for Joining us for the First-Ever Washington, DC Meeting of the Africa Regional SGBV Network!