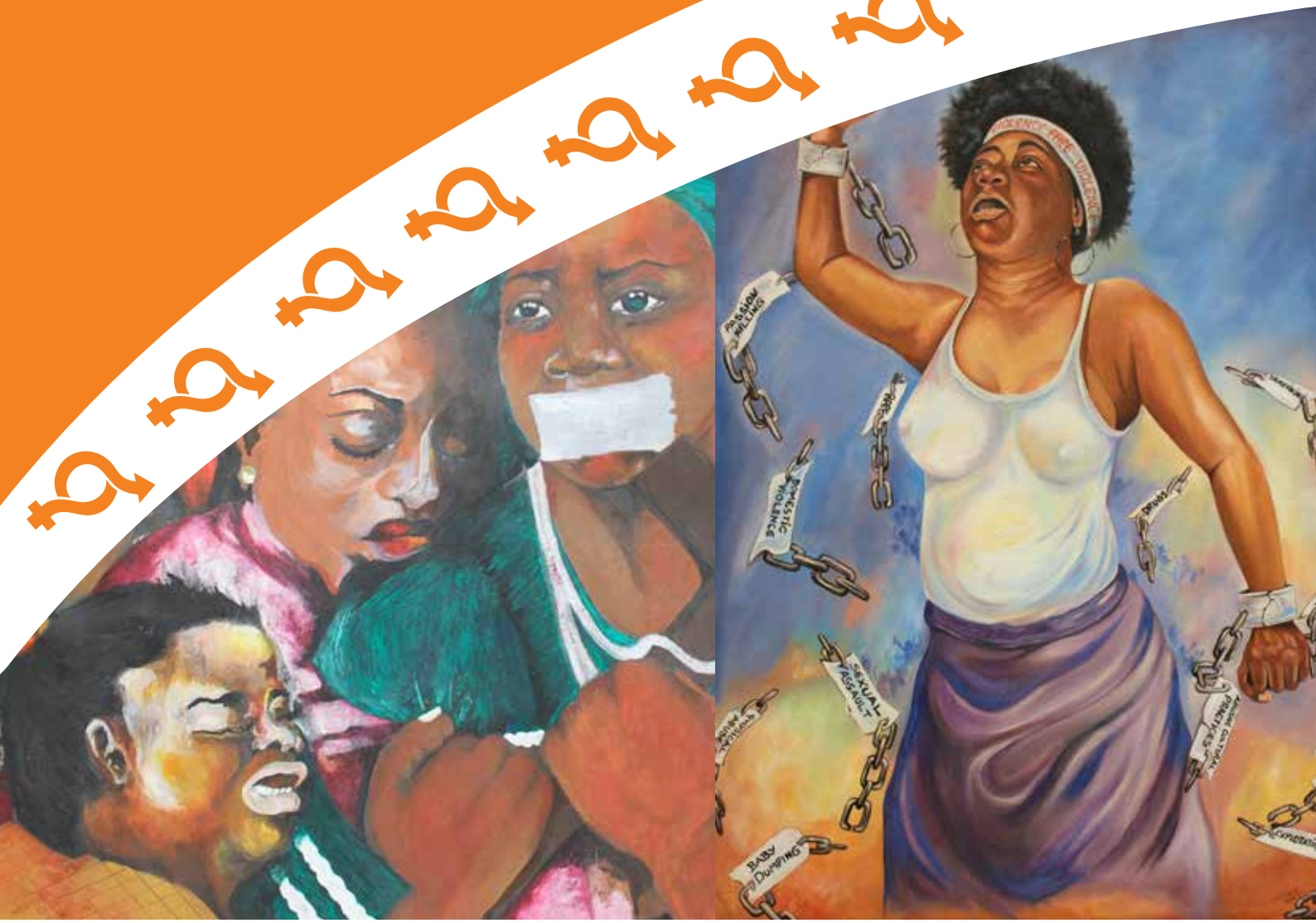
Gender-Based Violence (GBV) in Namibia: An exploratory assessment and mapping of GBV response services in Windhoek



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John Matthews and Inkeri von Hase were commissioned by Victims 2 Survivors and UNAIDS to carry out this assessment and prepare the report. However, the opinions and conclusions expressed within this report do not necessarily reflect the policies or views of the Government of Namibia, Victims 2 Survivors, UNAIDS or other partners that are mentioned in the document.

Layout & Design: Solitaire Press

Contents

List of Key Terms

CBO	-	Community Based Organisation
CLO	-	Community Liaison Officer
CSO	-	Civil Society Organisation
FBO	-	Faith Based Organisation
GBV	-	Gender-Based Violence
GRN	-	Government of the Republic of Namibia
IPS	-	Integrated Protective Services
LAC	-	Legal Assistance Centre
LGBTI	-	Lesbian, Gay, Bisexual, Transgender and Intersex
MoHSS	-	Ministry of Health and Social Services
MGECW	-	Ministry of Gender Equality and Child Welfare
MSM	-	Men who have Sex with Men
MSS	-	Ministry of Safety and Security
MOU	-	Memorandum of Understanding
NGO	-	Non-Governmental Organisation
NSF	-	National Strategic Framework
OVC	-	Orphans and Vulnerable Children
PEP	-	Post-Exposure Prophylaxis
SOP	-	Standard Operating Procedures
TAC	-	Technical Advisory Committee
UN	-	United Nations
UNAIDS	-	Joint United Nations Programme on HIV/AIDS
UNDP	-	United Nations Development Programme
WACPU	-	Women and Child Protection Unit

Acknowledgements

This assessment and mapping exercise would not have been possible without the assistance and involvement of a number of government and civil society stakeholders, as well as survivors of gender based violence that willingly provided their views and experiences in order to inform the review. In addition, the participants to the consultation meeting, which served to review and endorse the findings of the assessment as well as prioritize the recommendations, played a very important role in ensuring that the content represented reality.

Victims 2 Survivors and UNAIDS would like to express their sincere appreciation to Dr John Matthews and Ms Inkeri Von Hase who carried out the assessment and drafted the report, as well as acknowledge the leadership of Mr Henk Van Renterghem, Ms Hem Matsi and Ms Sarita Sehgal who provided guidance and oversight. Similarly, the valuable contributions of Ms Anais Marie and Ms Angelique Wernli in preparing the mapping as well as of Ms Nadia Guettou and Ms Lindsey Evans for supporting the consultation and finalizing the report are also acknowledged.

Executive Summary

This exploratory assessment of gender-based violence (GBV) response services in Windhoek is a follow-up exercise to two recent events organised and facilitated by Victims 2 Survivors, in collaboration with UNAIDS, UNDP, the MGECW and the National Art Gallery of Namibia. Both the Brandberg Climb in April 2013 and the 'Unite to End GBV' art exhibition in July/August 2013 (presented at the National Art Gallery of Namibia) sought to raise awareness and call for concrete action against GBV. As a registered non-governmental organisation, Victims 2 Survivors aims to create awareness and mobilize action against GBV by engaging in advocacy and lobbying for zero tolerance of GBV in Namibia.

The primary objective of the current study was to develop a preliminary understanding of the response to GBV in Namibia through a multisectoral assessment and mapping of available community-based services in Windhoek. While the prevention of GBV is of utmost importance and needs to be part and parcel of the national response to GBV, this study focused on the delivery of services to survivors of GBV due primarily to resource and capacity constraints. This was achieved by reviewing existing research and documentation at international, regional and national levels, carrying out unstructured interviews with key informants from a variety of sectors, and conducting a mapping exercise documenting GBV-focused services offered by NGOs, CBOs, CSOs and FBOs in Windhoek. Conversations were also conducted with survivors of gender-based violence and members of vulnerable populations, such as the LGBTI community and sex workers, to understand their perceptions related to the availability of services and challenges in accessing these services. The findings of this study provide a descriptive analysis of elements of the structural and institutional response to GBV in Windhoek and indicate some common challenges that survivors encounter when attempting to access services from the various sectors.

It is envisaged that this exploratory assessment may serve as an advocacy tool to encourage stakeholders including government, development partners and civil society to intensify their efforts to effectively prevent and respond to GBV so that all citizens of Namibia can realise their

rights and lead a life in peace and dignity. It is further hoped that this preliminary assessment may serve as a foundation for future research that fully describes the GBV response not only in Windhoek, but also in all of Namibia's 14 regions.

Included in the report are recommendations aimed at each of the main sectors investigated including government, community, civil society, health, law enforcement, and legal/judicial. The recommendations were developed based on the findings of the study and refined at a full-day consultative workshop held in Windhoek in October 2013. During this consultative meeting, participants identified priority recommendations, as well as developed a series of "next steps" for each identified priority recommendation. These next steps are the first attempts at identifying incremental changes that have the potential to act as a catalyst for larger systemic changes in the country.

Introduction

A study by the World Health Organisation has found that over one third of ever-partnered women in Namibia reported having experienced physical or sexual violence at the hands of an intimate partner at some time, with 31% reporting physical violence and 17% sexual violence.

Gender-based violence (GBV) is a human rights issue of endemic proportions in Namibia. One out of three women in Namibia have experienced or will experience GBV in their lifetime.[1] Gender-based violence has far reaching implications and lasting impacts on survivors, perpetrators, families, communities and the country as a whole. GBV is violence that is targeted against individuals or groups on the basis of their gender. GBV is a clear manifestation of deeply entrenched power inequalities between men and women. While it cuts across class, ethnicity, religion, ablebodiness, age and location, it disproportionately affects women and girls. The term GBV is hence often interchangeably used with 'violence against women'. According to the Commission on the Status of Women 'violence against women' means "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women and girls, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".[2] The term GBV has also been used to refer to any violence that is related to the socially ascribed roles of males and females, such as violence against men that is informed by norms related to masculinities and/or violence against gay, bisexual, transgender or intersex (LGBTI) individuals, which is informed by norms related to sexuality and sexual identity.[3]

GBV is a form of discrimination that seriously violates and impairs the enjoyment of all human rights and fundamental freedoms of survivors. GBV is not a series of isolated events, but rather represents a pattern of behaviour that undermines the dignity, autonomy and security of the

[1] Ministry of Gender Equality and Child Welfare, 2009 *Knowledge, attitudes and practices study on factors and traditional practices that may perpetuate or protect Namibians from gender based violence and discrimination*
[2] http://www.un.org/womenwatch/daw/csw/csw57/CSW57_Agreed_Conclusions_(CSW_report_excerpt).pdf
[3] http://www.humanitarianresponse.info/system/files/documents/files/gm-tipsheet-gbv-en.pdf

victims, limits their participation in society and damages their health and well-being. GBV comes at a high cost not only at the individual level with victims suffering from physical and mental harm, loss of earnings and increased healthcare costs; it also has wider societal costs, such as lower productivity and reduced economic output and growth, leading to heightened pressure on social and health services. GBV is thus not only a serious public health concern but also hinders the social and economic development of the country, and the achievement of internationally agreed development goals, including the Millennium Development Goals.

GBV can take many forms including physical, sexual, psychological and economic violence and needs to be seen as a part of a continuum of violence that violates internationally recognised human rights such as the right to life, freedom from torture, equal protection before the law, liberty and security of person, the highest attainable standard of physical and mental health and the right to be heard. It also violates the victims' right to control their sexuality.

GBV as a Public Health Issue

GBV is a significant public health issue as it has profound implications on the physical, mental and reproductive health of GBV survivors and their families. The physical health consequences of GBV include acute and chronic physical injuries and disabilities as well as homicide. Furthermore, GBV results in mental health problems ranging from low self-esteem and feelings of guilt to depression, anxiety, posttraumatic stress disorders and sometimes suicide. Rape and other forms of sexual violence can also negatively affect sexual and reproductive health leading to unwanted pregnancies, unsafe abortions, traumatic fistulas, baby dumping and sexually transmitted infections including HIV and AIDS. These consequences are introduced in Table 1, which details some of the common health consequences of GBV. While these are the direct external effects of GBV, this type of violence often reaches much further than the initial victims. For example, children who grow up in homes where violence is present may also suffer from emotional and behavioural health issues from witnessing one of their parents being abused. Further, being raised in an environment where violence is normalised can create the expectations that this is how adult relationships work, thus reinforcing in young children how to act, or what to expect when they enter into relationships in young adulthood.

Table 1: Health Consequences of Domestic, Intimate Partner and Sexual Violence

Physical Health	Mental Health and Behavioural Health	Sexual and Reproductive Health
Immediate injuries to the head, face, ear, nose, eyes and teeth, neck, upper torso, and abdomen, with abrasions, lacerations, burns, fractures & homicide. **Chronic Conditions:** • Headache • Fatigue • Chronic lower abdominal pain • Function limitation and disability • Chronic pain syndromes • Fibromyalgia • Gastrointestinal disorders • Premature mortality	• Depression • Anxiety • Post Traumatic Stress Disorder • Phobias and Panic Disorders • Sleeping Disorders • Low self esteem • Psychosomatic Disorders • Obesity and Anorexia • Alcohol and Substance Abuse • Aggression and Violence • Inter generational violence • Sexual risk taking • Self harm incl. suicide	Sexual and Gynaecological Disorders • Pelvic and Inflammatory Disease • STI/HIV/AIDS • Cervical Cancer • Sexual Dysfunction Obstetric complications • Unwanted pregnancy • Abortions (safe and unsafe) • Miscarriages • Premature labour • Low birth weight • Foetal injuries • Increased maternal, neonatal and infant mortality.[4]

Specific Linkages between GBV and HIV

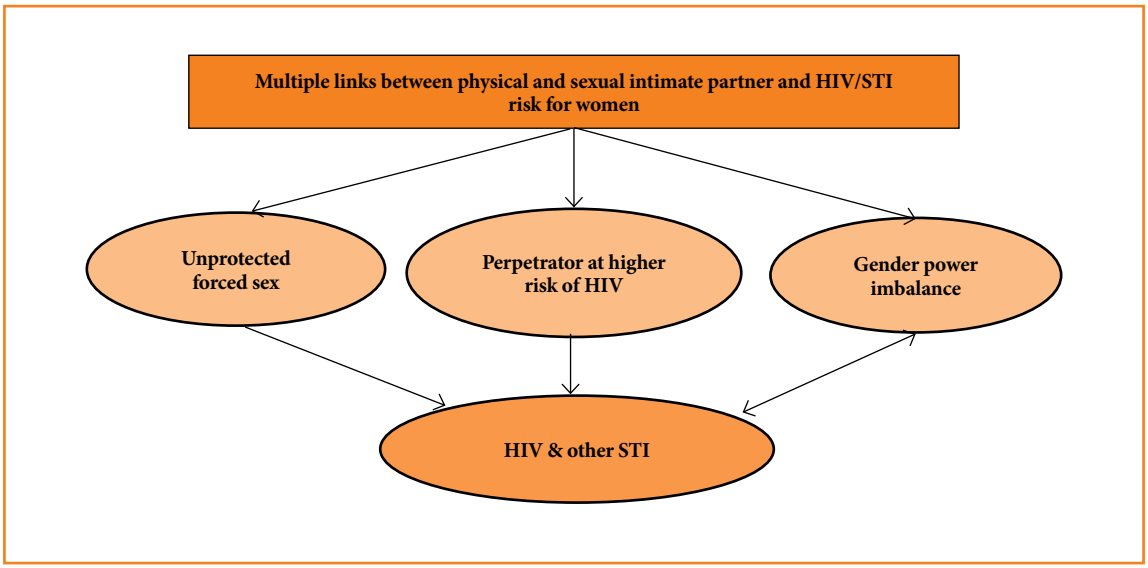
It is important to stress that GBV and HIV are mutually reinforcing epidemics with GBV being both a risk factor for HIV infection as well as a consequence of being infected with HIV. In the 2011 Political Declaration on HIV that resulted from the United Nations General Assembly High Level meeting on HIV, it was noted that the world community "remains deeply concerned that, globally, women and girls are still the most affected by the epidemic. They bear a disproportionate share of the caregiving burden, and their ability to protect themselves from HIV continues to be compromised by physiological factors. Further, gender inequalities, including unequal legal, economic and social status, insufficient access to health care and services, including for sexual and reproductive health, and all forms of discrimination and violence, including sexual violence and exploitation continue to increase the vulnerability of women and girls" (para.17).[5] This is consistent with the findings of international research on the links between HIV and GBV.

[4] World Bank, 2009, Gender-Based Violence, Health and the Role of the Health Sector [pdf], available at : http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTPHAAG/0,,contentMDK:22421973~pagePK:64229817~piPK:64229743~theSitePK:672263,00.html

[5] Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS. (2011). UN General Assembly. Retrieved from http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf

For example, studies find that women who experience violence in intimate partnerships face a four times higher risk of acquiring HIV.[6] In addition, fear of violence may hinder individuals from getting an HIV test, disclosing their HIV status, and seeking HIV treatment and care and may also deter them from negotiating safe sex. Further, international research indicates that HIV positive women report higher rates of intimate partner violence[7], and there is increasing evidence that HIV risk is linked to lifetime exposure to violence in complex ways. For example, rape is a potential cause of direct infection with HIV for some women – however, the likelihood of contracting HIV remains low from a single exposure. Rather, violence and gender inequality are more likely to increase HIV risk through indirect pathways, including chronically abusive relationships where women are repeatedly exposed to the same individual, and are unable to negotiate safe sex[8]. The links, both direct and indirect, are illustrated in the graphic below (Figure 1).

Figure 1: Links between GBV and STI Infection Risk for Women[9]



In Namibia, the prevalence of HIV is significantly higher among females with fifty eight percent (58%) of people living with HIV (PLHIV) being women and girls.[10] While all females experience a higher risk for contracting HIV, this risk is particularly pronounced among girls and young

7 Dunkle, KL, et.al. (2004). Gender-based violence, relationship power, and risk for HIV infection among women attending antenatal clinics in South Africa. The Lancet, 363: 1415-1421.

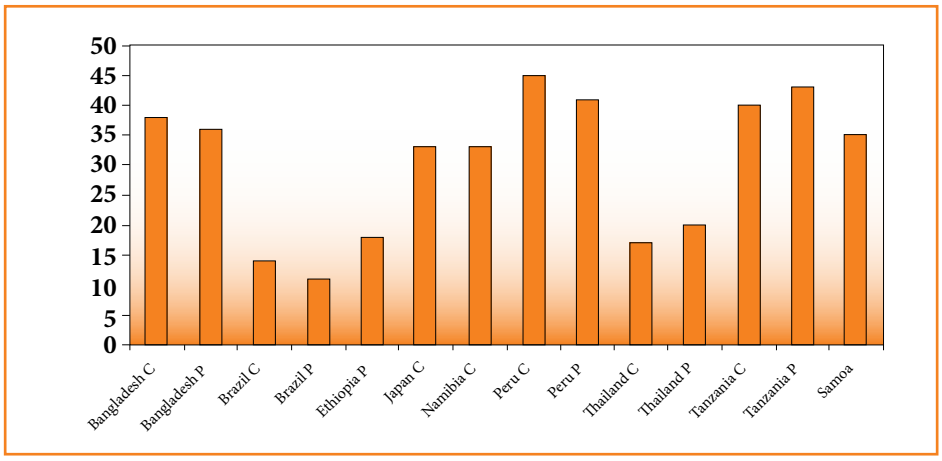
8 WHO/AIDS (2010). Addressing violence against women and HIV/AIDS: What works? Geneva, Switzerland. Retrieved from www.who.int.reproductive-health/topics/violence.

9 C. Watts, (2012), London School of Hygiene and Tropical Medicine.

10 UNAIDS Regional Fact Sheet 2012. Accessed on 29 August 2013 from https://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/gr2012/2012_FS_regional_ssa_en.pdf.

women. Results from an international comparative study (Figure 2) indicated that approximately 30% of all young women in Namibia reported their early sexual experiences, prior to age 15, as "forced".

Figure 2: Forced Sex among Girls and Young Women: International Comparisons



In addition to forced sex, young girls and women in Namibia experience an increased risk of becoming infected with HIV through the continuation of harmful cultural practices. For example, a booklet entitled "*Violence is not our Culture*"[11] details cultural practices from the Zambezi[12] region of Namibia that increase the risk of contracting HIV. These include:

- **Subordination of women through beatings:** Paying *lobola* allows a man to beat his wife or mistreat her. This is because it is like she was bought and she has no right to complain.
- **Coerced initiation into 'womanhood' – *Sikenge***: In some communities, the initiation ritual for girls and young women commences with their first menstruation, and serves to teach them to accept their gender role as wives and daughters-in-law who are submissive and obedient to their elders, their future husbands and their in-laws. The girls may be humiliated and beaten to enforce obedience and submission to their elders. A good woman is thus seen as one who is submissive and endures all forms of abuse in silence.
- **Preparation for sex and sexual readiness testing – *Kutamunwa***: During *sikenge* in some communities, girls and young women are also taught by the older women how to "dance"

11. Women's Leadership Centre. (2010) *Violence is not our culture: Women claiming their rights in the Caprivi Region.* Retrieved from http://www.wlc-namibia.org/images/downloads/violance_is_not_our_culture_eng.pdf.
12. The Caprivi region was renamed Zambezi in 2013.

– to move their bodies during sex in order to please a male partner. This is then 'tested' by male relatives, including uncles and grandfathers. Sometimes the testing is done without the knowledge of the girl or young woman, through the practice of *mulaleka* – having sex with a person who is in a dream state, drugged or through witchcraft.

- **Cutting and scarring young women's bodies – *Kupaza***: Another practice that is used to prepare young women for sexual relationships and marriage in some communities is the creating of scars on their back, waist and arms through cutting. Some women reported having up to one hundred scars on their backs and around their waists, as well as some on their arms. Girls and young women are taught that these cuts are necessary in order to attract and keep a husband. Herbs are rubbed into the cuts, creating scars that are said to keep boyfriends and husbands sexually interested and therefore faithful to their partners.
- **Drying out the vagina for 'dry sex' - *Kuomisa busali:*** Many girls and young women are taught that they must practice dry sex in order to give pleasure to the man and prevent him from leaving for another woman. Many women agree that having sex with a dry and tight vagina is painful and may lead to sores and infections, which increase their risk of contracting HIV.

While these customs are not practiced in all regions of Namibia, they do illustrate the myriad ways in which cultural beliefs shape the way that a person experiences the world and their role in it. With this knowledge, it becomes even clearer that it will be virtually impossible to stop the spread of HIV without addressing the larger structural drivers, such as gender inequality, which contribute to a cultural climate that supports the spread of HIV.

In a country such as Namibia, which aspires to achieve zero new infections and zero AIDS related deaths and has worked hard to scale up both prevention and treatment and increase options for care and support, this becomes particularly important. Recent modelling indicates increases in new infections amongst young women. The highest rates of new infections are estimated to have occurred amongst females aged 20-24, increasing from 13.1% of total new infections in 2010 to 14.1 % of total new infections in 2013. Amongst men, the highest rates of new infections are estimated to have occurred in the 25-29 age cohort, increasing from 8.4% of total new infections in 2010 to 9.4% of (total new infections in 2013). Approximately 53.4% of all new infections in

2013 are estimated to have occurred in the 15-29 age group, and 60% of new infections in this age group are estimated to have occurred among women.[13]

THE NAMIBIAN CONTEXT FOR GBV

One third of rape victims in Namibia are under the age of eighteen. [16]

Prevalence

In Namibia, gender-based violence is rampant. As per a report by the Namibian Police, rape was the most prevalent crime between January and April 2013 with 122 reported cases[14]. On average, there have been approximately 1075 reported cases of rape nationwide for each of the past four years (2009-2012).[15] However, it is likely that the number of actual rape and other incidents of sexual and physical violence is much higher as survivors often do not report the violence due to fear of reprisal from the perpetrator, family pressure, self-blame and/or societal stigma and discrimination. Women and girls are overwhelmingly targeted by rape accounting for 92% to 94% of complainants in reported rape cases. One third of rape victims are below the age of 18.[16]

The most pervasive form of GBV is domestic violence perpetrated by an intimate partner. According to police reports, the vast majority of victims of domestic violence are women (86%) and most of these crimes are perpetrated by men (93%).[17] A study by the World Health Organisation has found that over one third of ever- partnered women in Namibia reported having experienced physical or sexual violence at the hands of an intimate partner at some time, with 31% reporting physical violence and 17% sexual violence. The same study also revealed that 19% of respondents had experienced physical violence by a non-partner since the age of 15 and 6% reported sexual violence by a non-partner. The perpetrators of physical violence included teachers (26%), boyfriends (28%), fathers (19%) and female family members (19%), while the most commonly mentioned perpetrators of sexual violence were boyfriends (55%).[18]

13. Spectrum Policy Modelling System, Version 4. 69_500 (2013); Namibia Model 11 October 2013 as reported in the draft MTR of the NSF 29 October 2013.
14. NAMPOL, 2013 Crime statistics January to April 2013.
15. Ministry of Gender Equality and Child Welfare, 2013, An overview of gender-based violence in Namibia and government interventions [powerpoint presentation].
16. LAC, 2006 *Rape in Namibia: An assessment of the Operation of the Combating of Rape Act 8 of 2000*
17. LAC, 2012 *Seeking Safety, Domestic Violence in Namibia and the Combating of Domestic Violence Act 4 of 2003*
18. WHO, 2005 *Multi-country Study on Women's Health and Domestic Violence against Women.*

The 2007/2008 survey of knowledge, attitudes and practices relating to gender-based violence supports the high prevalence of GBV in Namibia with 34% of respondents having experienced physical gender-based violence. By disaggregating by sex, however, it becomes clear that women are the majority of GBV victims: 40.5% of women as opposed to 27.6% of men experienced GBV.[19] One of the reasons for the high prevalence of GBV in Namibia is the widespread cultural acceptance of violence perpetrated on the basis of gender. More than one-third of Namibian men (35%) feel that wife beating is justifiable for one or more reasons, and approximately 1 in 3 women feel that it is justifiable that husbands beat their wives.[20]

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Vulnerable Populations

Vulnerable populations such as LGBTI (lesbian, gay, bisexual, transgender and intersex) persons, MSM (men who have sex with men) and sex workers are particularly affected by GBV as per anecdotal evidence. However, there is currently no data available on the prevalence of GBV among these groups. Despite their heightened vulnerability they seem to be neglected in national GBV prevention and response efforts. The National Action Plan on GBV omits the heightened vulnerability of key populations, including the LGBTI community. However, the National Plan of Action does recommend reform of the legal framework on sex work, which has the potential to reduce vulnerability of sex workers in Namibia. Key informants highlighted that these groups have virtually no access to justice systems and limited access to SRH services, and if they try to access these services that they face high levels of stigma and discrimination. Moreover, sex workers appear to regularly experience physical and sexual violence from police officers and

19. Ministry of Gender Equality and Child Welfare, 2009 *Knowledge, attitudes and practices study on factors and traditional practices that may perpetuate or protect Namibians from gender based violence and discrimination*
20. Ministry of Health and Social Services, *2006-07 Namibian Demographic and Health Survey*

security personnel as a result of the criminalization of activities related to sex work. This state-sanctioned violence makes it difficult for sex workers to report cases of GBV, particularly if these acts were perpetrated by law enforcers.

Given the discrimination that is linked to non-conformity of social norms related to sexuality and sexual orientation, LGBTI persons regularly experience stigma and discrimination and are strongly affected by physical and sexual violence including hate crimes and "corrective rape". However, according to anecdotal evidence/spokespersons of the LGBTI community in Namibia, if they seek services by health professionals and police officers many experience further abuse stemming from discriminatory and judgmental behaviour by service providers.

Largely invisible in society, people with mental and physical disabilities are at increased risk of GBV due to their limited capacity for self-defence. They are recognized in the National Action Plan on Gender as a vulnerable group (Strategy 22) yet, there seems to be limited action in the current GBV response to provide them with specialized services and to reduce their vulnerability.

Costs

In Namibia, there are currently no available data that quantify the cost of GBV in terms of human suffering and economic indicators. There is no information available on either the direct costs (including treatment and support for survivors, and bringing perpetrators to trial) or the indirect costs (including days of work lost by both the abused and the abuser, the emotional cost in human pain and suffering by the victims and impacts on other family members, especially children). One of the reasons may be that given its hidden nature it is difficult to estimate the real prevalence of GBV and the resulting economic impact. However, such data are important in raising the urgency of taking concrete action to prevent GBV and providing survivors with comprehensive high quality services. The University of Namibia is currently embarking on a study in this area.

Legal and policy context

As a signatory to various international and regional legal instruments, such as the UN Convention on the Elimination of Discrimination Against Women (CEDAW), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, and the SADC

Protocol on Gender and Development, Namibia has committed itself to eliminate all forms of gender-based violence. This is reflected in the National Gender Policy (2010–2020), which identifies GBV as a major challenge to achieving gender equality. It stipulates the reduction of GBV and protection of women and girls as one of thirteen major policy objectives. To guide the implementation of this policy objective, the National Plan of Action on Gender-based Violence (2012–2016) was developed. The two key goals of this Plan of Action are to 1) reduce the incidence of GBV and 2) improve responses to GBV. In addition, there are two important pieces of legislation that specify that gender-based violence is a crime: the Combating of Rape Act no. 8 of 2000 and the Combating of Domestic Violence Act No. 4 of 2003.

Methodology

Design

The primary purpose of this assessment was to develop tentative understandings of the multi-sectoral response to gender-based violence in Windhoek by having focused conversations with some of the main stakeholders working in this area, and completing a mapping of available community-based services in the city. The stakeholders consulted included professionals representing government and civil society groups, as well as informal discussion with survivors of gender-based violence and members of vulnerable populations, such as the LGBTI community and sex workers residing in Windhoek. By incorporating multiple perspectives in the assessment, it is envisioned that these different views will describe the structural and institutional response to GBV and highlight some of the challenges that survivors encounter when attempting to access services from the various sectors.

The current assessment was designed as an exploratory, multi-sectoral rapid assessment. The exploratory nature of the assessment required the use of flexible methods to collect and analyse information. These methods allowed for emergent themes and shifts in focus based on the development of new knowledge that was gained from each consultation. Decisions regarding the scope and focus of the assessment were made after reviewing the existing research and documentation related to GBV in Namibia, as well as consulting regional and international research and best-practice standards including the guide for "*Conducting a Situation Analysis of Health Services for Survivors of Sexual Assault*"[21]. It is envisioned that this initial assessment can be used as a foundation for a future study that fully describes the GBV response not only in Windhoek, but also in all of Namibia's 14 regions. Furthermore, since the recommendations included in this document draw not only on the findings from the Windhoek assessment, but also on international and regional best practice, it is hoped that they can be taken into consideration for the entire country.

21. Sexual Violence Research Initiative (2006), Medical Research Council, South Africa.

Selection of Stakeholders

The sampling strategies for this assessment included the use of purposive and snowball sampling techniques. Purposive sampling is defined as the selection of stakeholders who are believed to yield the most comprehensive understanding of the phenomenon under review, based on the intuitive feel for the subject that comes from prior ethnography and reflection.[22] Essentially, an initial group of key stakeholders who were thought to have extensive knowledge related to the topic were selected to consult. Then, snowball-sampling techniques were used. This is where the initial stakeholders nominate others who may be potential informants.[23] Using these techniques, key informants were identified through referrals from other members in the community and during the initial consultations. In total, 17 key stakeholders working in the area of GBV, 6 survivors of GBV, and 6 members of vulnerable populations residing in Windhoek were consulted. Further, conversations were carried out with a variety of CBOs and NGOs with the aim of mapping community-driven services for those who experience, and/or are affected by GBV in Windhoek. The entry point for the identification of available community resources was the 2006 Resource Directory published by the Legal Assistance Centre.

Table 2: Key Stakeholder Consultations

Stakeholder Category	Number of Individuals Consulted
Government Sector (including social workers)	9
Health Sector (medical officers)	2
NGO Sector	6
Survivors of GBV	6
Vulnerable Populations (LGBTIs and sex workers)	6

Table 3: Specific Breakdown by Ministry

Government of the Republic of Namibia Ministry	Number of Individuals Consulted
Ministry of Gender Equality and Child Welfare	5
Ministry of Health and Social Services	1
Ministry of Safety and Security	4

22. Purposive Sampling in Qualitative Research (n.d.) Accessed on 8 August 2013 from http://www.gifted.uconn.edu/siegle/research/samples/purposivesampling.htm.
23. Chain Referral Sampling (2010). Accessed on 8 August 2013 from http://srmo.sagepub.com/view/the-sage-dictionary-of-social-research-methods/n192.xml.

Table 4: Mapping of Available Resources (Windhoek-Based)

Organisation Type	Number of Organisations mapped
Civil Society Organisations	12
Community-Based Organisations	4
Faith-Based Groups	5
Governmental Organization	1
Non-Governmental Organisations	12

Information Gathering & Analysis

The primary information-gathering methods for the current assessment included a review of available publications, individual consultations and a full day multi-sectoral stakeholder consultation. When considered together, these information-gathering approaches allow for a multi-dimensional assessment that explores the overall functionality of the GBV response in Windhoek and which incorporates the perspectives of a wide variety of stakeholder groups.

Additionally, this assessment incorporated the use of secondary data, primarily in the form of NGO/donor reports, national policy documents and existing research at international and regional levels regarding GBV. This secondary information provided data about the prevalence of GBV in Namibia, describes the expected service delivery system and provides information related to the overall policy landscape in Namibia. The regional and international literature provided information on best practices, which could potentially be relevant for Namibia.

Information Gathering Tools

The main information-gathering tool utilized in this assessment was an informal interview guide that contained a series of closed and open-ended questions. These questions were designed to explore key informants' and survivors' perspectives on the current landscape with respect to GBV in Namibia, to identify challenges for coordination, service access, and HIV mainstreaming, as well as potential methods to overcome existing barriers. Questions were developed for each of the primary sectors consulted, including health, government, NGO and survivors. It is important to note that while these guides provided a basis for the consultations,

there was flexibility to ensure that only relevant questions were asked of each key informant group and allowed for the exploration of issues that emerged during the consultation process.

Data Analysis

Essential data from individual conversations were captured using specially designed spread sheets. The spread sheets also created an audit trail whereby reported (summarized) data could be traced back to the original source material. The collected data were analysed using content analysis, whereby majority and minority reports were compared against the available literature in the relevant sector.

Limitations

Design decisions have inevitable consequences on the assessment's external validity, or the ability of the current assessment to be generalized beyond the population of people that were consulted. For example, the assessment relied on consultations with key members of various sectors in the community. However, not all relevant sectors could be consulted. In these cases, the findings are extrapolated from publically available data, such as national planning documents, policies and existing studies.

Multi-Sectoral Stakeholder Consultation: Refinement and Validation

Once the individual consultations were completed and the initial mapping of service providers was drafted, a multi-sectoral stakeholder consultation was held on 28 October 2013. The objectives of this full day consultation were to 1) review and comment on the draft findings and community resource mapping and 2) prioritise the recommendations and identify incremental steps needed to fully implement the recommendations. Over 20 stakeholders representing government, civil society, international donors, community-based groups, traditional leaders and academia attended the consultation and offered valuable insight into the draft assessment and the way forward. The information gathered through this process was integrated into the findings section of this document and is reflected in the prioritised recommendations and action steps that were endorsed by the consultation.


GROUP 1
MULTI-SECTORAL
① RAISE GBV to A NATIONAL EMERGENCY
② STRENGTHEN MULTI-SECTORAL COORDINATION MECHANISM TO BECOME FUNCTIONAL & EFFECTIVE
③ DEVELOP & USE A HARMONIZED DATA BASE/SYSTEM
④ ESTABLISH A FREE NATIONAL GBV HELPLINE

Findings

Introduction and Limitations

The findings presented in this section represent results from initial consultations with key GBV stakeholders and survivors in Windhoek, which were further refined and endorsed at a multi-sectoral stakeholder consultation held in Windhoek on 28 October 2013. While reviewing and analysing the data it became clear that contradictory information was being provided, even from stakeholders within the same organisation. While efforts have been made to ensure that all perspectives uncovered in the consultations are included in the findings, the authors fully acknowledge that these findings do not represent an "ultimate" truth, but rather represent the views of individuals who were consulted as part of the assessment. It is entirely plausible that the selection of a different group of key stakeholders could have yielded an alternative view of the systemic response to GBV in Windhoek. Thus, the findings should be interpreted as tentative, given the state of existing information in the area and the complexity of the phenomenon under review.

Findings

Survivors of GBV have a right to receive comprehensive government-supported care, including medical services, psychological support, police attention, legal assistance and access to justice. They also require adequate assistance and support from civil society organizations and community members in order to receive survivor-centred, high quality services. In the following section, the type, quality and accessibility of services will be explored per sector with a view to identify gaps and challenges.

The case study on the next page illustrates the experience of a GBV survivor related to accessing various response services.

CASE STUDY: ONE SURVIVOR'S EXPERIENCE OF DOMESTIC VIOLENCE AND SERVICE PROVISION

My husband started to beat me two years after we got married. Before that, he was a kind and loving man who would bring me flowers. This changed. In public, he carried on being a gentleman. People said he is a very good man. But when we were alone he was like a beast. He kicked me into my stomach, or used a hammer or iron stick to beat me up. I would have severe injuries, bleeding, bruises and blue marks. He used to scream and shout at me and insult me in front of our children, family and friends. I became so frustrated and hopeless. So, one day I told the pastor about what was happening at home, and asked for prayers. The pastor visited us at our house, but my husband chased him away. The pastor later said that no one could separate a wife and husband, only God or death.

The violence continued, so I went to the Women and Child Protection Unit (WACPU) several times. They were nice, but there are too few officers so they can't give you good attention because there are so many people seeking help. One night, I called them to come to my house because my husband got very violent. They said there is only one officer on duty and they cannot come. Another time I tried to call WACPU, but the phone was off. Then I phoned City Police to help me and they came very fast. WACPU officers advised me to move out of the house or that I could get a protection order from the magistrate's court. So I went there with my police statement, filled in the protection order form and got an appointment to see the magistrate after a couple of days. I explained to the magistrate my problem. I was given a temporary protection order, which two WACPU officers delivered, to my husband. They took him with the police car away from our house. After one month the temporary protection order ran out and we needed to go to court. The magistrate listened to both our stories and decided that my husband could go home. She warned him if it happens again within 2 years he would go to jail or pay a fine. So he moved back into the house and after 3 months the violence started again. I think the magistrate should not have allowed him to come back. I am also frustrated with WACPU because my husband is still not arrested. They say they cannot find him although I took them to the place where he works.

My husband had many affairs and often stayed with his girlfriends. Then he would come back and beat me. There was a period where he stayed away for one year. But one day he came home after being away for a long time and was very sick. He said he had flu. Our private doctor gave him medication but it didn't help. So I phoned the doctor and told her that I think it is something else. I told my husband that the doctor said we must go for HIV testing and he agreed. After one week she gave us the results. He was tested HIV positive, and I was tested HIV negative. This made things worse. He accused me of bewitching him so that I get his house and money. He was very violent. I didn't feel safe in my house anymore. At the fifth time of going to WACPU, I was told by a social worker about Friendly Haven so I went there together with my children. If they had sent me there earlier I would have made my decision to leave him sooner. There I became strong again and could reflect on what was happening in my life. I realised that it is better for my kids to grow up without a violent father, but I felt very sorry for them. At Friendly Haven I felt supported. They referred me for psychosocial counselling but I couldn't go because of work. But Friendly Haven staff comforted me and gave me hope. I didn't want to leave, but after two months WACPU said I have to go. So now I am renting a room from my sister and my children stay with their father. I see them after work and on weekends they stay with me. I am going through divorce now. Looking back at my situation, I would advise another woman who has just started to have these sorts of problems with her partner, to not sit and wait for better days. I would tell her to stand up and move on.

LEGAL AND JUDICIAL

In the Constitution of 1990, the Government of the Republic of Namibia outlines the rights of all citizens and the responsibility of government to protect these rights. While none of the articles contained in this document speak directly to GBV, they are all relevant to understanding Namibia's position toward GBV and its responsibilities toward its citizens. The relevant Articles include protection against torture, cruel, inhuman or degrading treatment or punishment (Article 8), freedom from discrimination (Article 10), fair judicial procedures (Article 12), freedom to form families through marriage (Article 14) and protect children (Article 15). Further, this Supreme Law articulates the role of the government in ensuring that fundamental freedoms are respected (Article 21) and that a functioning judiciary is in place to hear allegations of legal violations (Article 18).[24]

Namibia also benefits from a positive policy landscape designed to address gender-based violence. This includes the enacting of a variety of laws and policies that are relevant to GBV, which include:

- Vision 2030 (2004)
- National Policy on Orphans and Vulnerable Children (2004)
- Third National Development Plan (2008)
- Education Sector Policy for Prevention and Management of Learner Pregnancy (2011)
- National Gender Policy (2010-2020) and Plan of Action (2011)
- Namibia's National Agenda for Children (2012-2016)
- Children's Act of 1960 (child protection)
- Marriage Act 25 of 1961
- Combating of Rape Act 8 of 2000
- Combating of Domestic Violence Act 4 of 2003
- Criminal Procedures Amendment Act 24 of 2004 (vulnerable witnesses)
- Labour Act of 2007 (sexual harassment)

24. The Constitution of the Republic of Namibia (1990). Accessed on 13 August 2013 from http://www.gov.na/documents/10180/30001/Namibia_Constitution.pdf/a6050315-315a-4f65-8a0b-a7fe10a93258.

Furthermore, Namibia is a signatory to international Human Rights declarations, including: the Convention on the Elimination of All Forms of Racial Discrimination (CERD), the Convention against Torture and other Acts of Cruel, Degrading and Inhumane Treatment or Punishment (CAT), the Convention on the Elimination of Discrimination against Women (CEDAW) and the Optional Protocol to the Convention on the Rights of the Child. As a result of signing these international declarations, the Government of the Republic of Namibia officially becomes the duty bearer for protecting the rights established in these conventions. However, it has been reported in publications that "the country has in many ways failed to fulfil its international obligations in terms of failing to report to the committees set up for each convention, and in many cases by failing to implement and enforce the obligations set out in the instruments concerned in its domestic laws."[25]

Previous research also reports the challenges of navigating the Namibian legal system by concluding that "the Namibian legal system and the administration and institutions supporting it are cumbersome, often overly regulated and generally not user-friendly."[26] In this same report, the cost of accessing quality legal services is discussed as a barrier to accessing such services. Despite the efforts made by the state to provide legal aid and paralegal programmes supported by civil society groups for the poorest members of society to enforce their rights, the cost of legal advice continues to exclude many from the courts. The problem is exacerbated by the high costs of legal and administrative proceedings."[27] This is especially relevant for survivors of GBV from lower socio-economic strata who cannot afford private lawyers and who seek an order of divorce from the courts.

Combating of Domestic Violence Act of 2003

The Combating of Domestic Violence Act of 2003 lays the foundation for addressing GBV in Namibia by outlining an inclusive definition of GBV that includes physical abuse, sexual abuse, economic abuse, intimidation, harassment and serious emotional, verbal or psychological abuse in a variety of relationship categories.[28] This act also provides the mandate to create nationally

25. Chomba, S. The universality of human rights: Challenges for Namibia. Accessed on 13 August 2013 from http://www.kas.de/upload/auslandshomepages/namibia/HumanRights/chomba.pdf.
26. The Justice Sector and Rule of Law in Namibia. Accessed on 21 August 2013 from http://www.nid.org.na/pdf/publications/Management%20Book%20Fianl%2026_05_11.pdf.
27. Legal Assistance Centre. (2012). *Seeking Safety: Domestic violence in Namibia and the Combating of Domestic Violence Act 4 of 2003 (Summary Report).* Windhoek: Legal Assistance Centre.
28. Government Gazette of the Republic of Namibia. (2003, June 24. Accessed on 15 August 2013 from http://www.lac.org.na/laws/pdf/domvio.pdf.

available structures and procedures to allow survivors of GBV to obtain a protection order. These protection orders can address the following areas: orders of 'no contact', forced removal from shared premises, financial support, and provide guidance regarding shared assets, property and minor dependents.[29]

It was noted in the consultations with key stakeholders that there is a lack of consistently applied procedures in the legal/judicial system. For example, one stakeholder noted that the disposition of applications for protection orders were dependent on the individual magistrate hearing the case. Because of this, being able to move a case forward is dependent on whether a magistrate is "on board". If they are not, then the case cannot go forward. However, an applicant has the right to appeal if an application for a protection order is refused. One interviewee reported that they have learned that they often have to reapply if the case application was not positively received the first time it was presented. Additionally, it was noted in previous research that availability of services remains a weakness in the protection system, including inconsistent support for those who need assistance in completing the application form, as well as the lack of a uniform system for dealing with after-hours applications.[30]

Some stakeholders have identified a lack of GBV sensitivity by members of the legal/judicial sector as a barrier for survivors to access services. It was further noted that more purposefully aligned systems need to be designed and implemented. For example, when a victim files an application for a protection order, the magistrate on duty hears it. However, this magistrate does not permanently and exclusively work on GBV issues, but rather periodically rotates through this type of assignment. The problem with this lack of dedicated, permanent court staff working on GBV cases is illustrated in the following survivor story: "I was issued an interim protection order, but then when I went to court for the criminal case, the magistrate decided my husband could go home, but warned him if the violence occurred within the next two years he would have to go to jail or pay between N$2000-N$4000. So, he moved back in after three months, and it started again".

29. Legal Assistance Centre (2012). *Seeking Safety: Domestic violence in Namibia and the Combating of Domestic Violence Act 4 of 2003 (Summary Report).* Windhoek: Author.
30. Narnia Bolher-Muller (2001). *Valuable lessons from Namibia on the combating of rape.* South African Journal of Criminal Justice, 14(1), p. 74.

Once in court, the survivor of GBV is subjected to the will of the individual magistrate, who may not be sensitized to GBV. For example, one survivor, who believed that her husband's wealth and access to power allowed him to 'handpick' the magistrate who would hear the case reported being told: "Shut up! Must you always be the one that must be heard?" The survivor further explained: "The magistrate said I must occupy one room in our house, not to talk to him, but still clean and cook. During the divorce process, I was only allowed to live in one room, and for two years I did not speak to him. I was told if I leave the house it would be considered to be 'malicious desertion' in the divorce proceedings." During the review of a working draft of this document it was pointed out that this is a common misperception, but is in fact, a legally incorrect one, and that the concept of 'malicious desertion' would not apply in the above example.

Further, if the case goes to trial, then it becomes the responsibility of the Public Prosecutor to follow through with the case. It was noted by key stakeholders that like many other sectors, this office is overloaded with work and understaffed. Those consulted for this assessment also expressed that there is, in general, a lack of empathy for victims of crime, particularly those who have experienced GBV. Thus, as has been noted in other sectors, the attitudes of those providing services may have an impact on whether individuals choose to access services initially, or proceed with a criminal case.

Combating of Rape Act of 2000

According to the National Plan of Action on Gender Based Violence, Namibia's Combating of Rape Act "has been hailed as one of the most progressive laws on rape in the world".[31] This legislation is characterized by a gender-neutral definition of rape that uses a lens of 'coercive circumstances' to articulate the illegality of a variety of sexual acts that can be prosecuted using this act. Further, this act articulates the impact of the survivor's privacy, provides for the opportunity for the victim to testify at the bail hearing on the accused, and provides minimum sentencing guidelines for rape – which range from 5-15 years for first offenders depending on the circumstances of the crime.[32] The legislative definition of rape utilized in Namibia does include

31. Legal Assistance Centre (2006). *An assessment of the operation of the Combating of Rape Act 8 of 2000.* Windhoek: Legal Assistance Centre.
32. Stop Violence Against Women (n.d.). Other Related Offences: Criminalization of Marital Rape. Accessed on 20 August 2013 from http://www.stopvaw.org/other_related_offences_criminalization_of_marital_rape.

rape within marriage in terms of section 2(3) of the Act: "*No marriage or other relationship shall constitute a defence to a charge of rape under this Act.*"[33]

It was noted by key stakeholders that despite this legislation, there remain challenges to fully implementing this law. For example, men who experience sexual assault are required to be seen by the surgeon on duty at the casualty unit rather than by the state doctors (gynaecologists) assigned to work with WACPU cases in which the victims are female. Second, it has been noted in previous research that women choose to withdraw rape cases for a variety of reasons, including:

- The woman received compensation
- The woman was pressured by her family to withdraw the case
- The woman feels ashamed that she was raped
- The rapist physically threatened the woman to withdraw her case
- The timetable for the prosecution of a rape case is too long
- The woman feels that she has insufficient evidence to win her case
- The woman lacks the necessary information
- The rapist occupies a position of status in the community
- The woman was bribed to withdraw her case
- The woman is in a position of financial distress[34]

An overarching theme of these reasons listed above includes the intersection between civil law and customary law. For example, the level of poverty that exists in Namibia may be a contributing factor to using customary law to settle this type of case. The complainant and their family may be offered tangible compensation (in the form of cash or livestock) that may be perceived as being more beneficial than going through the civil legal system. Other factors, such as those associated with the systemic response may also influence a person's decision to withdraw the case. The considerable time and effort that it takes for a case to make its way through the legal/judicial system may contribute to women withdrawing cases. They could simply be ready to move on with their lives, and the lack of closure on the legal case does not allow for this to happen. Third, a complainant may seek to withdraw a rape case because they fear a lack of evidence will support their claims. For instances where a person is sexually assaulted, she or he must be

33. Legal Assistance Centre (2009). Withdrawn: Why complainants withdraw rape cases in Namibia. Windhoek: Author.
34. ibid

physically examined (preferably within 72 hours of the assault to secure forensic evidence) by a trained physician who documents the abuse using a J88 form. This evidence is required for the prosecution of a case in court. In the absence of this evidence, it becomes one party's word against the other. Finally, it must be noted that stigma and shame remain incredibly common and can influence a person's decision to withdraw a rape case. This may be even more prominent in the case of male victims, who may feel marginalised as the focus of GBV and sexual assault is almost exclusively on women.

In some cases, survivors of GBV can become overwhelmed at the prospect of navigating the legal/judicial system. This is where the efforts of civil society groups, such as the Legal Assistance Centre (LAC) play a key role in the GBV response in Namibia. By providing support to GBV survivors through the provision of education and referrals, as well as producing basic summaries of complex legislation, such as the Combating of Rape Act and the Combating of Domestic Violence Act, individuals who have experienced GBV are provided with the basic information needed to understand their rights and what systems exist to protect those rights. For many individuals, the services offered by LAC combined with the limited Legal Aid provided by the government are the primary source of legal education/advice/referrals in the country.

GOVERNMENT SECTOR

Services provided by the Government provide the foundation of publicly available care and support for GBV survivors in Namibia. These services are provided primarily by the Ministries of Health and Social Services, Gender Equality and Child Welfare and Safety and Security. The MGECW recently launched a National Protection Referral flowchart that was collaboratively developed with several key ministries, and civil society with the exception of the MOHSS. This document outlines the expected path that a person seeking assistance after experiencing GBV follows to access services in Namibia. It is a useful backdrop to explore perceptions of challenges with respect to service access, coordination and quality assurance across the continuum of care.

Service Access

According to an official at the MGECW, there are future plans for one-stop centres where survivors of GBV can access services in each region. This model is based on services offered in other southern African countries and has been piloted in the Kavango region. It is envisioned

that there will be one centrally located facility in each region, ideally near to a health care facility, where any person can go to 1) report GBV and open a police docket, 2) seek psychosocial support from a social worker, 3) access legal advice and support for filing an application for a Protection Order, 4) receive a medical exam and treatment, as well as PEP treatment and emergency contraceptives in the case of sexual assault. It is important to note that in Namibia, the responsibility for the GBV response does not rest with one ministry, but rather is spread across different ministries, including MGECW, MOHSS, MOSS, and MOJ. Each of these ministries serve complimentary roles within the service delivery system.

Table 5: Mandate of Line Ministries

Ministry	Mandate
Ministry of Safety and Security	Opening police dockets, investigating suspected criminal activity.
Ministry of Gender Equality and Child Welfare	Provide psychosocial support and programming (shelter, support, counselling) for survivors of GBV.
Ministry of Health and Social Services	Provide physical care for people who experienced GBV, administer and document results of sexual assault kits (J88).
Ministry of Justice	Public Prosecutors are charged with supporting legal cases brought by survivors of GBV, magistrate's court is responsible for hearing petitions for protection orders.

When a person experiences GBV, the first stop in Windhoek should be the WACPU located at Katutura Hospital. Key stakeholders who were interviewed as part of this study expressed the belief that most women know that this is the first point of entry into the referral system after experiencing GBV. It was noted, however, that many males who experience GBV do not know that this is the first point of entry and often go to police stations (this was detailed in the recent WACPU evaluation study – and is fully addressed in a separate section detailing barriers). Once at the WACPU, survivors are given the opportunity to meet with a WACPU Police Officer to give a sworn statement of the event and are advised about possibilities of opening a police docket for investigation, or beginning the process of applying for a protection order. Survivors are also able to begin accessing social and health services at the WACPU centres. For example, there are three social workers employed by the Ministry of Gender Equality and Child Welfare, but posted to the WACPU. There is a position for a Senior (Control) Social Worker at this unit, but it is currently vacant. One social work intern from the University of Namibia assists in providing psychosocial support services, as do interns placed at Friendly Haven, the only shelter in Windhoek for women who have experienced GBV. There are no social workers from the

Ministry of Health and Social Services posted at the WACPU. It was understood that there is currently not a permanently situated staff member at WACPU to provide legal support and advice, which is one of the components of the one-stop service delivery model.

While the WACPU unit is physically open during regular business hours Monday-Friday from 8:00 am to 5:00 pm, the Chief Inspector reports that individuals can report GBV at any precinct, and that roving officers collect these after-hours reports for further processing at the WACPU centre. However, key informants indicated that WACPU officers on stand-by are reluctant to go to the scene of a crime after-hours and refer survivors to police stations. At the stakeholder consultation, it was noted that the on-call staff sometimes do not answer the telephone during the evening or weekend, take a very long time to respond and sometimes do not respond at all. It was also reported that one of the social workers is on-call 24 hours per day, 7 days per week to attend to any emergency cases identified by police, including a 100% response rate to all reported sexual assaults and violence involving children. In reality, the lack of transport coupled with the demand for services, as evidenced by very large caseloads, means that social workers have limited mobility to go out to victims of GBV and they are advised to come to WACPU the following morning or on Monday.

If the survivor has experienced sexual assault during the incident, the individual must have a Sexual Assault Evidence Collection examination conducted by a trained physician. This process is fully described in the Health sector findings. Social workers explained that the sexual assault kit must be completed within 72 hours of the incident if there is to be any evidence collected. They reported difficulty in getting the doctor to come and administer the kit if more than this length of time has elapsed as they conclude there is no evidence left to collect.

All sexual assault kits are conducted by rotating state doctors who are trained gynaecologists. There is no assurance that an individual can receive services from a same-sex medical provider, or one who speaks the primary language of the patient (the appointment of non-Namibian doctors in state hospitals who do not speak any local language and have limited English proficiency is well documented). In the event that a male reports an incident of sexual assault, the examination process is handled a bit differently. Rather than the state doctor coming to the WACPU facility to perform the exam, the patient is advised to go to the Casualty Unit at

the Katutura Hospital where the surgeon on duty must be the one to conduct the examination. Given the stigma associated with male sexual assault, and the need to go to the general hospital and wait for services in the general waiting room, this could be a contributing factor of low levels of male reports of GBV, particularly in the event of sexual assault. It is important to note that it was not possible to identify or obtain written clinical guidelines that establish standard treatment protocols to be used in cases of rape/sexual assault.

Further, it was reported by social workers that the only cases that are seen by doctors at the WACPU are sexual assault cases of women and girls. The Casualty Unit at the local hospital attends to all other cases of abuse. It was also reported that social workers would accompany the clients to the hospital depending on the severity of abuse, staff availability, and the assessment of the perceived level of trauma and whether the survivor has a support person with them to accompany them to the hospital. The social workers accompany all cases involving minors to the hospital, and mentioned that the waiting times can be very long given that there is no official arrangement for giving priority to GBV cases at the hospital – thus the client (and the accompanying social worker) must wait in the queue for an undetermined period of time. It was reported that in some cases, the survivor (and social worker) can sit in a queue all day, only to be told the doctor has gone for the day and that they must return again the next day to continue waiting to be examined.

Once the initial examinations have been completed and when the client is able, the social workers from the MGECW can conduct a comprehensive psychosocial assessment and begin to assist the client in addressing any identified needs. The social workers are trained to provide services to individuals, families (mediation and family therapy), groups, and engage in community mobilisation. However, due to staffing limitations, it was reported that individual and family intervention is the most common form of assistance. The social workers that were consulted reported having a desire to assist survivors with establishing community-based support projects, but cited the overwhelming need of new and existing clients at the WACPU as a barrier to supporting community projects after their initial formation.

MGECW social workers apparently do not receive special training in working with individuals who have experienced acute trauma or GBV, and reported no sensitivity training related to GBV

as part of the induction training. Rather, they report learning from each other and from working with Senior Social Workers at the MGECW. Individuals who have experienced GBV receive services for an unspecified length of time. There do not seem to be any standard treatment guidelines or regulations with respect to the quantity of services that should be offered. Rather, each social worker makes an individual determination as to when the best time is to terminate the case. There also does not seem to be any written protocol outlining expectations for follow-up with clients who have accessed services at the WACPU. The social workers at WACPU expressed a desire to follow-up with clients, but reported that it is not always possible. Staffing constraints and lack of transport were cited as the primary reasons for not consistently following up with individuals receiving services.

Data related to GBV is captured in two separate databases at the WACPU units. One is for the Ministry of Safety and Security, and the other is for the Ministry of Gender Equality and Child Welfare. These data are used to establish access levels at the regional level, and in theory, are fed into a national database. It is reported, however, that this national database, which is the responsibility of the national staff at the MGECW, is currently not functional. Thus, there appears to be a lack of a comprehensive, regularly updated GBV database that facilitates tracking and monitoring of gender-based violence crimes. This is a serious challenge since a functional and harmonized database documenting unique cases is essential to properly document, manage and respond to reported cases of violence, and to monitor compliance with laws and policies. National reports generated by such a database would help generate strategic evidence to inform policymaking and programming. It was noted in the stakeholder consultation that USAID has provided funds to secure the services of consultants to develop a functional and user-friendly database that will be accessible to all agencies and organisations providing GBV services.

HEALTH SECTOR

Before seeking health services, victims are expected to first report cases of GBV to the police or the Women and Child Protection Unit (WACPU) where they are provided with a medico-legal examination form and referred to the relevant health provider. A GBV survivor is apparently not able to receive health care by state practitioners without producing this form from the police. This effectively obliges survivors to make contact with the police, which they may be reluctant to do for various reasons including fear of and/or lack of faith in the justice system, shame of being

abused, limited mobility, long queues and limited confidentiality due to lack of private rooms at police stations. This requirement may cause GBV survivors to hide the cause of their injury or even prevent them from seeking medical services.

There appear to be different pathways for victims to follow depending on whether they have experienced sexual or physical violence in order to access medical services from state hospitals in Windhoek. Victims of physical abuse are attended by nurses and doctors at the Katutura Hospital Casualty Unit where they wait to be seen like all other patients, i.e. there are no private waiting rooms for GBV survivors. In contrast, survivors of sexual violence are examined by doctors from the Katutura State Hospital's gynaecological and obstetrics department in a private room at the Women and Child Protection Unit (located on the hospital grounds) using a pre-packaged rape kit. Only medical officers are authorized to administer the rape kit (there are different rape kits for adults and juveniles), and the presence of a same-sex police officer is mandatory (however, if the survivor requests it then apparently the investigating officer is required to leave the room). The administration of the rape kit (which seems to be consistently available at WACPU) serves to collect forensic evidence. In addition, the doctor completes the specialized J88 medico-legal examination form noted above. It should be noted that the J88 forms differ for sexual vs. physical violence, but there is no sub-section or specific form for emotional violence. The J88 form is not only a prerequisite for police investigations and court proceedings but also to access abortion services.[35] If a J88 form has not been completed, vital evidence is missing and alternative forms of evidence need to be employed such as statements by witnesses. In the case of abortion, the magistrate needs to be fully convinced that the pregnancy is the result of the alleged rape, which can be difficult if the J88 form was not completed within 72 hours or is not completed at all.

The Ministry of Justice does not supply private doctors with rape kits, or evidence documentation forms included with these kits. According to key stakeholders, private doctors also appear reluctant to provide care to rape survivors, as they apparently prefer not to appear in court, due

35. Under the 1975 Abortion and Sterilisation Act, abortions are allowed only in the following circumstances: 1) when continuing the pregnancy will "endanger the woman's life or constitute a serious threat to her physical or mental health or 2) when there is a serious risk that the child to be born will suffer from a physical or mental defect so as to be irreparably seriously handicapped, 3) when the foetus is alleged to have been conceived in consequence of unlawful carnal intercourse (rape or incest); or 4) when the foetus has been conceived in consequence of illegitimate carnal intercourse and the woman is, owing to a permanent mental handicap or defect, unable to comprehend the implications of or bear the parental responsibility for the "fruit of coitus"".

to perceived inefficiencies in the legal system. This is a challenge for rape survivors who would prefer to receive medical services from their private doctor, and it essentially obliges them to go to state health facilities. State doctors are compelled to testify as witnesses in court, however in reality this rarely happens. One doctor emphasized "in three years I have been working here, I did it only once". During the review of the working draft of this assessment, it was pointed out that amendments to the Criminal Procedure Act allow for factual information recorded by a doctor to be admitted into court without personal testimony. However, conclusions from this evidence are not admissible without testimony from the person who collected the evidence.

One of the doctors highlighted that the utilization of rapid HIV test kits "would be a good idea to save time".

The majority of doctors working in the Katutura State Hospital's gynaecological and obstetrics department are male so medical service provision to a rape victim by a same-sex provider is not guaranteed. As explained by one of the doctors who were consulted: "She has to be seen by whoever is on call." This may further traumatize survivors of GBV.

HIV testing and counselling forms part of the examination. However, rather than performing a rapid HIV test, a blood sample is taken and sent to the laboratory. One of the doctors highlighted that the utilization of rapid HIV test kits "would be a good idea to save time". Patients are advised that if the test results are positive, then the HIV infection is not resulting from the reported rape incident. The patients are given advice about ART and are referred to the ART clinic. They are also informed that if they test negative, they should repeat the HIV test regularly after the incident. The survivor is invited to a follow-up appointment within 7 days during which she/he is given the results of the blood test by a social worker who reportedly received training in HIV counselling. The rape incident is noted down in the medical passport of the survivor (which may jeopardize the patient's right to confidentiality) as is the need to provide the survivor with Post-Exposure Prophylaxis (PEP) within 72 hours,

emergency contraception and antibiotics. The survivor is then requested to get the medication from the head sister at the casualty section. It would save the survivor considerable time and effort if the medication would be given directly by the medical doctor at the WACPU and reduce the 'back and forth' that survivors of GBV typically experience.

While medical care is theoretically available 24/7 to survivors of physical GBV at Katutura Hospital's Casualty Unit, in reality it seems that survivors often have to wait for extended periods to be seen by a doctor, especially at night. In some cases, survivors have to come back the following day if the medical officer on duty did not see them. This also applies for survivors of sexual violence. If they seek health services after hours, they may have to wait for WACPU to open in the morning for the examination unless an investigating officer on stand-by is there to follow through with the case and phone the social worker and doctor on stand-by for the medical examination.

Neither medical officers of the gynaecological and obstetrics department nor doctors and nurses at Casualty appear to receive comprehensive or standardized GBV sensitization training. The administration of the rape kit and collection of forensic evidence is acquired on a learning-by-doing basis or shown to medical officers by a senior doctor. It was reported by one stakeholder that the National Forensic Institute sent a team around the country to train doctors in forensic evidence collection. However, no concrete data on the status of this initiative could be confirmed. This lack of specialized training may affect the quality of service provision to GBV victims and potentially have unintended negative consequences.

Stakeholders highlighted that the LGBTI community and sex workers are particularly affected by discriminatory attitudes from health professionals resulting in many GBV survivors from these groups not seeking medical services.

Key stakeholders voiced concern about the lack of understanding and empathy by health staff. This is particularly relevant in the context of emotional violence and the resulting harm thereof. One of the survivors who shared her experience for this assessment expressed: "They don't understand psychological violence because they cannot see it". A key informant articulated a similar sentiment regarding the lack of sensitization of health professionals: "They make gender-based violence ok at the hospital grounds". Others referred to discriminatory and judgmental attitudes including blaming the survivor for the experience of GBV. They indicated that comments like "You deserve it; you must stop sleeping around" are common. Stakeholders highlighted that the LGBTI community and sex workers are particularly affected by discriminatory attitudes from health professionals resulting in many GBV survivors from these groups not seeking medical services.

Doctors indicated that health service delivery could be optimized by ensuring staff receive special GBV training by employing a full-time doctor at WACPU and/or by recruiting and training forensic nurses (this recommendation was also supported in a 2006 report by the Legal Assistance Centre). As stated by one doctor: "I think it is very good if a nurse could administer the rape kit because it would decrease waiting hours for survivors." This echoes the views of key informants from civil society who identified the need to fast track the medical service provision to GBV survivors and to sensitize nurses and doctors of the different manifestations of GBV. They also emphasized the need to limit the 'back and forth' referral of GBV survivors by adopting an integrated and comprehensive approach to service delivery. However, it is important to note that services are provided according to the standards outlined in national policies. One stakeholder from the MGECW noted that there is no provision in national policies that authorizes nurses to perform these examinations, and that the first step to addressing this issue is to amend the Act and recognise a category of nurses as "Forensic Nurses".

"I think it is very good if a nurse could administer the rape kit because it would decrease waiting hours for survivors" – A physician at a state health care facility.

Health professionals do not tend to make referrals outside the health sector such as to legal aid, safe houses or civil society organizations. Monthly incidence reports are also not compiled nor are they requested to be shared with the MGECW, the lead agency for GBV. One of the doctors lamented the fact that there is currently no functional system of information sharing in place.

Psychosocial counselling is provided by social workers at the WACPU, all of who are currently holders of Baccalaureate (4 year) social work degrees who have generalist training. Specialized social work services (MA level) or psychological assessment/counselling by psychologists/ psychiatrists is not offered at the WACPU, but are made available through referrals from social workers. However, key stakeholders reported that a lack of effective coordination between the ministries often resulted in survivors being bounced back and forth from MGECW and MoHSS when trying to access psychological services. The conversations with survivors indicated that they tend to seek counselling from civil society organizations or from faith-based organizations/ groups in addition to support from government programmes.

LAW ENFORCEMENT SECTOR

The Women and Child Protection Unit (WACPU), administered through the Ministry of Safety and Security, holds primary responsibility for opening criminal dockets cases, as well as investigating all allegations made by complainants. WACPU deals with cases of domestic violence, rape, kidnapping and murder, but does not handle cases of common assault. The cases that WACPU does not deal with are referred to police stations that do not always have private consultation rooms, and therefore may affect the confidentiality of GBV survivors. During this assessment process, consultations were carried out with several key stakeholders from the WACPU office in Windhoek, which included members of the national office of MOSS and several survivors of GBV. Most of the survivors indicated that the WACPU and/or normal police stations were the first point of call to seek help. The views on the services provided by WACPU differed significantly. While one respondent said she received friendly and helpful treatment, another gave her view that "They are the worst. They further traumatize you."

According to WACPU officers, there are currently WACPU units in every region of Namibia (with two each in Hardap and Karas). These offices host 102 police officers that are assigned to work at the WACPU units. Until recently, WACPU was organized as a unit, but it has now

been restructured into a sub-division. This is in line with the GRN's goal of decentralisation. The new structure provides for the establishment of sub-units in each of the regions, under the guidance of a regional WACPU coordinator, who in turn reports to the National Liaison Officer. It was reported that with decentralization comes a risk of not being able to communicate a coordinated, comprehensive approach to stakeholders, including donor agencies that support the work of the WACPU units. A related concern was the challenge of ensuring coherency in the national GBV response as well as data collection strategies.

The primary responsibility of the law enforcement sector involves the investigation of allegations of gender-based violence. According to one key informant, police officers try to find and arrest perpetrators immediately after a survivor has reported GBV. If found, the perpetrator will be arrested and must have an initial court appearance within 48 hours of being detained.

The WACPU office is staffed during regular business hours, has on-call Officers 24 hours per day, 7 days per week and has roving officers who travel between precincts to receive GBV reports that are taken from precinct officers. While officers are on-call 24 hours per day, one officer reported that survivors are referred to normal police stations for physical assault, "only in serious cases do we get up at night". Every morning, WACPU officers drive to police stations to see if cases were reported, pick up dockets and call victims to ask them to come in. At the initial interview at the WACPU station, the statements are reviewed, rewritten if necessary, and an initial decision is made regarding the status of the case. If a formal complaint is made, a WACPU officer is assigned to handle the investigation and prepare the case for further processing.

The WACPU has been criticized by survivors for the lack of 24-hour services and lack of responsiveness concerning to calls for help after hours.

The WACPU has been criticized by survivors for the lack of 24-hour services and lack of responsiveness concerning calls for help after hours. One survivor said that whenever she phoned WACPU at night there was either no answer or she was told that they could not come to

the crime scene due to lack of staffing. Therefore, she preferred to phone City Police who would arrive promptly. Another respondent highlighted that there are no sufficient female officers and that she preferred treatment from a woman. She said "The female police officer was best because she could feel as a woman what I felt." This criticism of a lack of 24-hour services was also identified in an informal conversation with the Chief Medical Officer in one of Namibia's northern regions. While this is anecdotal evidence, it does provide credibility to the authors' assertions that even though this study focuses on the service delivery response in Windhoek, many of the findings are applicable at a national level.

Currently, the process of opening a docket and assigning a case for investigation is done using paper records. However, according to one key stakeholder, a new E-Policing system is being piloted in three regions for eventual rollout across the country. This new system features electronic records and has the ability to track an individual's criminal behaviour throughout the country. Further, when fully functional, this new system will enhance efficiency in terms of assigning cases for investigation, as well as collecting data that can be used for crime reporting.

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During conversations with WACPU staff, it was clear that the 13 officers posted in Windhoek (there are 16 positions but currently only 13 active officers) are faced with a heavy workload, including an average of 200 victims of GBV seeking information and/or accessing services in the city every month. Survivors of physical violence are apparently often sent to normal police stations due to high workload at WACPU. They are given a stamped J88 form that they take to the doctor to complete. The survivor then needs to take the form back to the police station where a docket is opened if

desired by survivor. If a survivor prefers not to open a docket, the perpetrator may be issued with an official warning statement that is filed/documented, or the survivor is informed about the different protection order options. While WACPU officers see approximately 200 survivors per month, it was reported that on average, very few GBV cases reported to WACPU (will) eventually result in formal criminal proceedings that are followed all the way through the judicial process. The issue of withdrawing criminal cases is fully explored in the Legal/Judicial section of this report.

According to survivors, there are too few officers to provide services to those in need. This results in a slow and inefficient managing of cases.

GBV survivors interviewed as part of this assessment expressed their concern that the number of officers is too few to cover the volume of people seeking help, resulting in slow and inefficient management of cases. As noted above, some mentioned that their abuser has not yet been arrested, as police officers have been unable to locate the perpetrator despite having received information about the perpetrator's whereabouts from the survivor.

While the WACPU is designed to serve all members of the community, it was reported that typical service users are individuals from non-white ethnic groups, those of lower socio-economic backgrounds, and residents from primarily the Katutura area. Officers estimated that males report approximately 10% of all GBV cases in Windhoek and represent 12% of reports nationally. As was previously discussed in the governmental sector, men appear to have less knowledge of the role that WACPU plays in addressing GBV in Namibia. Thus, it is assumed that they are more likely to approach a general police station with their complaint. To address this barrier, it was recommended in the recent WACPU evaluation study to change the name of the WACPU to IPS (Integrated Protective Services) or IPSU (Integrated Protective Service Units) to reflect the provision of services to males, as well as to women and children at WACPU units.

General police stations may be problematic service access points, particularly since general police officers have not historically received GBV sensitivity training. To address this barrier

to service provision it was reported that starting in 2013, all new police recruits would receive basic sensitivity training related to GBV. Further, in order to ensure the professional readiness of police officers to serve at WACPU units, personal interviews are now being conducted with all police officers that apply for these postings.

As has already been noted, key populations, including sex workers and LGBTI individuals, may have an increased risk of experiencing GBV. However, if they seek services by health professionals and police officers they may experience further abuse stemming from discriminatory and judgmental behaviour by service providers. One of the key informants recounted his experience of being arrested for involvement in illegal sex work by a police officer, who raped and infected him with HIV. When he tried to lay charges against the perpetrator, the police commander warned him "You are not supposed to report police officers". Another informant indicated that remarks such as "Go and sort yourself out before you come back!" are common insults to LGBTI persons, which reduces their incentive to access GBV response services.

Effective 2013, all new police recruits will receive basic sensitivity training related to GBV. Further, in order to ensure the professional readiness of police officers to serve at WACPU units, personal interviews are now being conducted with all police officers who apply for these postings.

A variety of data is collected by the WACPU offices, which are then reported to the regional coordinators. The collected data include type of violence (and whether alcohol was involved), number of suspects, arrests, whether the cases involve children or adults, withdrawn cases, and the outcomes of the court case (if applicable). This data is then transferred from the regional level to be inputted into a National Database, which is managed by the Criminal Statistics Unit. This

data is compiled into a larger monthly report detailing crime in Namibia. As previously noted, the existing databases from the relevant ministries are not interlinked, thus, there is currently no mechanism for data to be consolidated to carry out comprehensive analyses.

Intersectoral Coordination

The primary sectors that interface with the WACPU are the legal/judicial systems (described in a previous section) and the health and social work sectors. One WACPU staff member identified the links between the Ministry of Justice and Ministry of Safety and Security as being the most relevant. However, this was also pointed out as a weakness in the system. It was reported that there is a lack of regularly scheduled national intersectoral coordination meetings between ministries. In 2008, a National Advisory Committee on GBV was established to advise Cabinet on issues related to GBV through the chair of the MGECW, but one key stakeholder reported that this committee became dormant because it did not have regularly scheduled meetings or on-going tasks, but instead came together only to address specific projects. This was further emphasized by another key stakeholder who commented, "I am a member of the committee but I have never been called. We do not meet and we do not give each other feedback. There is a big gap in the coordination of our efforts." However, it should be noted that this committee is currently in a process of restructuring based on the 'clusters' defined in the National Gender Policy, and in the future, subcommittees will be established to focus on specific cluster issues.

"I am a member of the committee (National Advisory Commitee on GBV) but I have never been called. We don't meet and we don't give each other feedback. There is a big gap in the coordination of our efforts." – Key Stakeholder

Despite the challenges, there is evidence of collaborative activities such as the National Referral Protection Network, on which the MGECW and MOSS jointly collaborated. Further, a Crime Technical Advisory Committee (TAC) meets quarterly in Windhoek and includes representatives

from the National Police Headquarters and the Head Offices of the Ministry of Safety and Security. It was reported that although GBV is a standing item on this committee's agenda, the TAC is focused on crime in general.

Another coordinating structure is the Impact Mitigation CTAC (chaired by MGECW), focusing on HIV and the national AIDS response in Namibia, which has been merged with the Permanent Task Force on Orphans and Vulnerable Children. This structure is functional, and has regular meetings. Two of the standing items on this TAC's agenda are OVC issues and GBV, as it relates to HIV. One key informant indicated that the committee largely focuses on OVC issues, and that gender issues are rarely addressed due to the high levels of services needed by OVC. It was noted in the stakeholder consultation that USAID provides funding for a Gender Advisor who is placed at the Gender Directorate through Lifeline/Childline. One of the focal areas for this advisor is GBV, specifically on the implementation of the National Action Plan on GBV.

Inadequate communication and coordination among key role-players from different ministries and other stakeholders limits the effectiveness of GBV interventions.

-National Plan of Action on Gender Based Violence (2012-2016)

Despite the evidence of attempts at coordination between the various sectors, this is still identified as a major limiting factor in Namibia's GBV response. According to the National Plan of Action of Gender Based Violence (2012-2016), it is noted that "inadequate communication and coordination among key role-players from different ministries and other stakeholders" limits the effectiveness of interventions. In the plan of action, health and forensic evidence matters are identified as particularly weak points for intersectoral coordination and an integrated service response.[36] This is also reflected by the limited linkages between GBV and HIV services, despite the fact that available evidence indicates that these epidemics mutually reinforce each other.

36. National Plan of Action on Gender-Based Violence (2012-2016). Windhoek: MGECW.

As described in a recent gender analysis of the National Strategic Framework for HIV/AIDS 2010/11-2015/16[37] (NSF), the NSF states that women and girls are disproportionately vulnerable to HIV because of gender based violence and describes how OVCs, women living with HIV and men who have sex with men experience high rates of violence or fear of violence.[38] It also states that the NSF will "focus on addressing gender and income inequalities, gender based violence and sexual abuse, social and sexual norms and creating an enabling environment for people to access and utilise prevention services". Indeed, one of the guiding principles of the NSF is Gender and Human Rights and it states that strategies will be developed and implemented to address GBV.

However, the implementation of the NSF has not sufficiently focused on the linkages between HIV and GBV, and the coordination in this regard has not been effective. There are missed opportunities to address GBV, build awareness of women's rights and create an enabling legal system by mainstreaming GBV prevention in the planned activities related to HIV. The recent mid-term review process of the NSF has provided an opportunity to strengthen action to address these linkages, and the revised NSF, which is currently being finalized, highlights the need for integrated action and services.

One area where conflicting data was collected centred on the intersectoral coordinating committees. It was the view of some individuals that the committees were largely comprised of individuals from upper management levels who are somewhat removed from the day-to-day operations and interventions targeting GBV in Namibia. Thus, it was suggested to include operational staff on any coordinating committees to incorporate a practical perspective. Alternatively, it was also suggested by other stakeholders that one of the weaknesses of these committee structures is that after the initial commencement of the committee, ministries elected to send junior staff that lack decision making power or subject knowledge to represent them.
While consultations with key stakeholders illustrate how the system should work, conversations with survivors of GBV and the review of secondary data sources provides an additional angle through which the system can be analysed. For example, an evaluation of WACPU was conducted in 2012, which resulted in a number of key findings related to the law enforcement response to

37. Gender Analysis of the National Strategic Framework on HIV, UNAIDS and MGECW, 2011 (unpublished).
38. NSF (34, 20, 15).

GBV, including: variability in the quality of statement taking and completion of affidavits, poor follow up (including crime scene investigations), filing of appropriate charges, risk assessment, and attention to confidentiality. In addition, it was found that the current institutions and structures are insufficient to allow for a prompt and thorough response to allegations of GBV. It was further reported that WACPUs have limited capacity to provide an adequate response and that there is an absence of standard operating procedures that ensure that victims of violence are provided with integrated services.[39] However, it is important to note that the lack of coordination is not specific to this particular sector. Indeed, the multi-sectoral response to HIV as outlined in the NSF Coordination Framework 2011/12-2015/16 has also encountered challenges in implementation. Lack of adequate coordination most likely reduces the effectiveness of service delivery and integrated service responses across all sectors.

Programmes operated by the Government of the Republic of Namibia (GRN)

- Collection and dissemination of monthly returns for GBV cases reported to all police stations and mobile police satellites countrywide.
- Legal literacy program targeting Key service providers (Life skill teachers, Traditional Leaders, Church Leaders, Police, Defence force members) and community members.
- Community sensitization on GBV
- Incorporation of Domestic Violence in the National Studies (Demographic Health Survey 2012/13).
- Mass media campaign on GBV
- 16 Days of Activism against GBV
- GBV studies

39. Assessment of woman and child protection services in five regions to inform development of an integrated system (2012). Windhoek: MSS & MGECW.

CIVIL SOCIETY SUPPORT

Civil society plays an important role in ensuring access and availability of comprehensive survivor-centred services. They provide critical assistance to individuals who are affected by various forms of GBV, lobby government and other stakeholders for the development and implementation of comprehensive policies and programmes, and are involved in monitoring and evaluation of national efforts. In Windhoek, there are a number of non-governmental organizations (NGOs) that provide services to survivors of GBV including Friendly Haven, LAC, Women's Solidarity, Philippi Life Trust, Peace Centre and Lifeline/Childline. These organizations provide a wide range of services to GBV survivors such as psychosocial counselling, legal assistance, provision of information, referrals, hotlines, safe housing for abused women and their children as well as research, lobbying and advocacy. Further, while not specific to GBV survivors, there are exist women's empowerment programmes or income-generating/skill transfer projects operating in Windhoek. These groups can assist GBV survivors to improve their negotiating power within and outside the home and regain their self-esteem and autonomy. Furthermore, there seem to be limited initiatives that seek to transform the current set of gender norms, roles and behaviours that sanction GBV. That said, it is important to highlight that changing harmful gender relations is mainstreamed into Lifeline/Childline's work. There are nonetheless only limited initiatives that seek to effectively enhance community awareness, outreach, and mobilization concerning GBV prevention and response and rights literacy. Efforts aimed at increasing male involvement in the context of preventing and responding to GBV are also somewhat limited. In addition, there is also limited service provision by civil society to populations who are particularly vulnerable to GBV such as LGBTIs, MSM and sex workers. The majority of the NGOs consulted

LifeLine ChildLine (LLCL) has run a counseling help line for children for over 30 years. Although there is a crisis line for adults, a large percentage of callers on the toll free child line (116) are adults; many of
these calls are GBV related.

These findings stress the urgent need for a GBV help line where victims, perpetrators and all affected directly and indirectly can call for responsible and sensitive advice, counseling and guidance accessing the service system.

LLCL's GBV helpline is still in the partnership building stage with both Government and other partners and is expected to be operational by the end of 2014 with support from USAID.

focus on female survivors of GBV with little support being available for men and boys who experience GBV. There also appear to be limited, if any, rehabilitation or therapeutic programmes offered for perpetrators of violence to learn and adopt alternative forms of behaviour and reintegrate into society. Furthermore, the overwhelming majority of NGO clients are from lower socio-economic groups. This does not mean that individuals of middle and high-income brackets are not confronted with GBV. Rather, it indicates that more affluent GBV survivors seem to have different coping mechanisms in place and make use of private service providers (such as physicians, psychologists and/or lawyers), stay with friends and family or pay for accommodation if they feel no longer safe in their own home.

MenEngage, a program run by Lifeline Childline, sets out to strengthen male involvement in activities and interventions that aim to achieve gender equality and respond to SRHR and GBV issues.

While all NGOs have a record-keeping system in place, only a few of them have adopted systematic follow-up procedures to ensure that survivors and their families receive adequate post-trauma services. All the NGOs indicated that they partner with other civil society organizations as well as relevant line ministries with referrals being the most common form of collaboration followed by combined advocacy efforts. However, they pointed out that coordination amongst key stakeholders, including line ministries, is a persistent challenge which may be due in part to perceived competition for scarce funding among civil society organizations. Many of the NGOs consulted lamented the limited availability of funding from government, which makes it difficult for them to provide sustainable services to GBV survivors. Some NGOs also pointed out the importance of outsourcing services to civil society to expand and strengthen survivor-centred service delivery. A consultant supported by USAID is spearheading this outsourcing of cases requiring continuing care and support. The referral pathways will divert cases to appropriately trained/qualified staff at NGOs for on-going psychosocial support to individuals who have experienced, or been affected by GBV.

All interviewed NGOs indicated that HIV is integrated into their service delivery. This is typically done by referring clients to voluntary HIV testing and counselling facilities or by providing information on the linkages between GBV and HIV. Some NGOs also collaborate with organizations that primarily work in the area of HIV and AIDS. However, all civil society organizations consulted voiced their concern that the twin epidemics of GBV and HIV are not addressed in an integrated manner by national policies and programmes. One key stakeholder proposed: "national policies should be reviewed to integrate GBV and HIV/AIDS". Others indicated that even if GBV is recognized as a driver of HIV infection in key policy documents like the National Strategic Framework for HIV and AIDS Response, the design and implementation of programmes to simultaneously tackle both epidemics is lacking. None of the NGOs involve survivors in programming efforts, but some mentioned that former clients became volunteers helping others to better cope with their life situation.

As was noted above, there is only one women's shelter in Windhoek run by Friendly Haven, which can house up to 18 women and children. Despite high prevalence of GBV in the capital, the occupancy rate of Friendly Haven is low at an average of 30%. This low occupancy rate points out not only limited awareness among communities on the existence of women's shelters, but also a lapse in the referral system. Women can only be accommodated at Friendly Haven upon referral by WACPU, psychologists and civil society organizations such as Lifeline/Childline, Peace Centre and the Legal Assistance Centre. Although WACPU is responsible for the majority of referrals, only a small number of women who seek help at WACPU seem to be referred to Friendly Haven. This means that not all survivors are informed by social workers and/or WACPU officers about the possibility of seeking safety in the shelter.

Despite a high prevalence of GBV in the capital, the occupancy rate of Friendly Haven is low at an average of 30%. This low occupancy rate points not only to limited awareness among communities on the existence of women's shelters but also to a lapse in the referral system.

One of the survivors said that she was only informed about Friendly Haven at the fifth time she came to WACPU for protection and support. She highlighted "If they had sent me earlier to Friendly Haven I would have made the decision to leave my abusive husband earlier". In rare cases, women seek shelter at Friendly Haven without referral. In these situations, they are advised to seek assistance from WACPU, or after-hours they are accommodated and WACPU is notified the following morning. There is no permanent social worker placed in the shelter and there are currently a number of social work interns working in the shelter. Abused women and their children can stay up to 21 days in the shelter (although exceptions are made for particularly vulnerable women), after which they are encouraged by social workers placed at WACPU to look for alternative places of accommodation. Given limited financial means of survivors and lack of transitional housing and low cost housing for people affected by GBV, this leaves them vulnerable and many have no other option but to move back in with the abuser, which perpetuates the spiral of violence. Furthermore, there do not appear to be any safe spaces for men who experience GBV in Windhoek.

The vast majority of NGOs indicated that survivors of GBV obtain only limited assistance and care from community-based organizations or groups.

Desert Soul, a Namibian NGO, recently launched a new EU supported programme that aims to empower women and girls to access services and obtain their rights as constituted within national laws and policies. It aims to create an enabling environment by sensitising duty bearers on their roles and responsibilities for the protection of the women and girls against exploitation, violence and abuse.

The project will also assist communities to develop community protection mechanisms that allow women and girls at household and community level to challenge a culture of violence, seek help and report abuse in a timely fashion.

COMMUNITY RESPONSES

A cohesive and resilient community has mechanisms in place to support and protect vulnerable members in order to maintain social capital. However, it seems that the community system response to GBV is weak in Windhoek. Community mobilization, face-to-face education and grassroots level service provision related to GBV appear to be limited. One explanation may be

that there continues to be widespread social acceptance of violence. According to a 2009 study on the knowledge, attitudes and behaviours related to GBV, physical and emotional violence was considered culturally acceptable given its consistence with traditional social norms and the notion that private matters were not the business of the community.[40] The cultural acceptance and associated taboo nature of talking about GBV result in limited action by community members to address GBV. The widespread silence around GBV also makes it difficult for survivors of GBV to open up to community members and request help. Furthermore, informal discussion with young peer educators following the assessment has indicated a sense of weak social cohesion within communities and among neighbours, which may be exacerbated by high levels of inequality.

According to a 2009 study on the knowledge, attitudes and behaviors related to GBV, physical and emotional violence was considered culturally acceptable given its consistence with traditional social norms and the notion that private matters were not the business of the community.

The most prevalent form of support at the community level appears to come from traditional leaders who can act as mediators between the family of the survivor and the perpetrator of violence. However, traditional leaders seem to only be consulted in serious cases of violence such as rape, and compensation is pursued according to customary law, typically in the form of livestock, which is transferred from the perpetrator to the survivor's family rather than to the survivor herself. There appears to be no mechanism in place to ensure that the compensation is indeed effected, or that the survivor agreed with this approach to resolving the issue. If the victim is a minor or unmarried woman, the family may be consulted and given authority to make decisions on behalf of the victim. In addition, the majority of traditional leaders in Windhoek are male, which may result in a limited understanding of the experiences of female GBV survivors. Furthermore, one may argue that the application of common law, which is in line with international norms and standards on gender equality, may be more effective in punishing and condemning gender-based violence and enforcing zero tolerance on GBV.

40. Ministry of Gender Equality and Child Welfare, 2009 *Knowledge, attitudes and practices study on factors and traditional practices that may perpetuate or protect Namibians from gender based violence and discrimination*

AVP Namibia – Alternatives to Violence Project – is addressing the lack of mediation between victims and perpetrators in Namibia. Currently, AVP is developing communication skills for mediation in schools, prisons and communities.

Another area which has been highlighted by community partners as requiring attention is the facilitation of communication between the actual survivor (not the family or relatives as noted above) and the perpetrator. Many survivors (sooner or later) have to face their offender, and although each of them may have received individual physical and/or emotional support, there appears to be a gap when it comes to supporting renewed interaction between them. AVP Namibia is seeking to support action in this area.

The deliberate culture of silence around GBV, in addition to feelings of guilt and self-blame, render it difficult to seek help and to get actively involved in the community to address GBV through awareness campaigns, community mobilization and advocacy. In this context, key stakeholders also referred to the generally weak service provision and lack of coordination within communities. One respondent said: "If our services that we are providing to GBV survivors were better, women would come out and speak about this silent disease". Another informant highlighted: "Nobody organizes survivors of GBV so they cannot rise". With regard to this last comment, the recent campaign "Unite to end GBV" has initiated awareness and mobilized young people to speak out against violence.

In April 2013, a group of 25 women and men consisting of activists, representatives from different NGOs, artists as well as radio personalities climbed Mount Brandberg in Namibia. The aim of the climb was to advocate for behavioural change and raise awareness about GBV in Namibia. This was followed by an art exhibition entitled "Unite to end GBV" which was accompanied by a number of side events, including video screenings, radio shows and panel discussions and sought to mobilize young people and promote dialogue on this sensitive issue.

Another form of community-based support derives from churches and prayer groups. Typically, church members pray for victims of violence and/or organize commemorations for individuals who have passed away because of GBV. Pastors also provide marriage counselling and seek to mediate between wife and husband based on values and norms described in the bible. It appears that women's subordinate role in the marriage is emphasized and obedience and forgiveness is stressed. This may not necessarily encourage women to seek medical, police and legal services and/or leave abusive relationships.

A glaring gap in the community response to GBV is the absence of support groups for survivors. There seems to be only one support group in Windhoek (called the Brave Women Foundation) consisting of female members that are affected by GBV and HIV/AIDS. Furthermore, there appear to be no support groups for perpetrators of violence at community level. This is in contrast to support groups for people living with or affected by HIV, which are relatively well organized in comparison. A recent mapping of PLHIV support groups in Windhoek indicated that there are more than 40 support groups in the city and most of these are active in the informal settlement areas. A consultation with representatives of these support groups revealed that they are highly affected by gender based violence as well as HIV, and indicated the need to draw closer linkages and indeed explore the possibility of making use of these support groups to also support GBV survivors.

Young Namibian GBV artists vote to end AIDS and GBV at the top of Mount Brandberg, April 2013

Recommendations

A comprehensive series of recommendations was developed as part of this rapid assessment (See Annex 1). These recommendations include multi-sectoral recommendations, as well as suggestions for each of the sectors analysed during this project. One of the key objectives of the stakeholder consultation was to review the recommendations and develop a set of priorities based on whether the suggestion was relevant for Namibia, how feasible it would be to implement in Namibia, and the level of urgency associated with the recommendation. As part of this process, the stakeholders also identified "next steps" that were required to implement the suggested recommendations. It is critical to note however, that strengthening and expanding existing efforts to prevent and end all forms of gender-based violence is of crucial importance, which requires meaningful actions and on-going political commitment of the Government of Namibia and relevant stakeholders, backed by adequate resources.

Prioritised Recommendations
1) Classify Gender-Based Violence (GBV) as a national emergency
a. Use 16 Days of Activism and Orange Days to raise awareness b. Empower/Charge GBV advisory committee to raise issues with politicians c. Line ministries should integrate GBV issues into Employee Assistance/Workplace Wellness programmes
2) Strengthen the Multisectoral Coordination Mechanism (GBV Advisory Committee) to ensure it is functional and effective
a. Capitalise on USAID funded Gender Advisor in MGCEW to accelerate implementation of the GBV action plan. b. Build GBV capacity of GBV advisory committee members and gender focal persons in ministries and organizations c. Implement a gender budget for Namibia

3)	**Develop a comprehensive and harmonized system for effective documentation of incidents of GBV**
	a. USAID to contribute funds for a consultant to develop an accessible and user-friendly national GBV database b. All stakeholders should be trained on accessing and entering data into this database c. National level statistics and reports should be used to inform/influence politicians and influence the development of future strategies
4)	**Establish a free national GBV helpline**
	a. Set up the infrastructure and generate support from relevant line ministries for the GBV helpline b. Involve the private sector, such as MTC and TN-mobile, to get free services c. Develop a marketing campaign to publicise the helpline
5)	**Develop relevant standards and protocols to guide service provision**
	a. Solicit funding and hire a consultant to assist in developing required standards b. Hold a consultative workshop with all relevant stakeholders to present draft standards and receive feedback c. Secure final approval and launch service standards in relevant sectors (health, social services)
6)	**Integrate GBV survivors support into reproductive health and HIV programmes**
	a. Sign a MOU with key ministries (MoHSS, MGECW etc.) to clarify the roles and responsibilities of each sector b. Raise public awareness of the links between GBV/HIV/SRHR through a media campaign to include radio, TV, and social media c. Provide capacity building for key stakeholders through cross training for GBV and HIV providers, as well as sensitivity training for all sectors
7)	**Provide survivors of GBV with immediate and long-term psychological counselling to reduce trauma**
	a. Provide specialized training to social workers, law enforcement, shelter staff, health staff and judiciary b. Outsource long-term counselling to CSOs, FBOs and NGOs. Sign service agreements with the relevant stakeholders c. Provide specialised training in court preparation and witness support to key staff members

8)	**Increase the involvement of men and boys in preventing and responding to GBV using a human-rights based approach**
	a. Recruit counsellors, influential people from schools, communities, and churches to serve as champions of these efforts. Publicise the efforts of the organisations b. Educate key staff from identified organisations on human rights, GBV and its effects, harmful cultural practices, and gender roles c. Empower key persons to form a social movement to educate community members and support men and boys to speak out against GBV
9)	**Increase government funding of civil society response services for GBV survivors**
	a. Increase outreach and education efforts so that politicians understand the importance of addressing the GBV issues in the country b. Create a cohesive advocacy strategy and increase lobbying activities c. Encourage government to become an active partner with civil society to address GBV issues nationally, including a focus on unserved and underserved populations
10)	**Implement programmes focusing on women's empowerment to help victims develop a sense of autonomy and increased self-esteem**
	a. Form support groups that focus on GBV issues. Recruit members through radio, TV, and newspaper advertisement b. Integrate life skills and income generating projects into support groups to foster a sense of independence among members, and promote sustainability of the groups c. Assist members in promoting their economic empowerment initiatives to the larger community

Conclusion

This exploratory assessment provides an initial analysis of the service response to GBV in Windhoek and highlights some service access and coordination challenges across the continuum of care. While the government and civil society partners should be commended for their efforts to provide GBV focused services, it is clear that more concrete action is required to improve the delivery of comprehensive, survivor-centred services. More needs to be done to optimize user-friendliness of response services, to ensure safety both at the individual and community level, strengthen referrals and collaboration between key stakeholders and service providers, and ensure that systems, including those that measure quality assurance, service access, and data collection databases are operational. Based on these key findings, the practical recommendations presented in this report have the potential to support the country to improve the GBV response and make an immediate, positive impact on the lives of people who have experienced GBV in Namibia. It is only through a well-articulated vision and accompanying, coordinated multi-sectoral action that Namibia will be able to move closer to protecting its most vulnerable citizens.

ANNEX 1: LIST OF FULL RECOMMENDATIONS

The section begins with multi-sectoral recommendations followed by sector-specific recommendations. These recommendations draw on international and regional best practice that are relevant for Namibia, as well as the findings, which emerged through the exploratory assessment in Windhoek.

Multi-sectoral

1. Raise GBV to a **national emergency** issue that urgently needs to be tackled in a coordinated and harmonized manner.

2. **Cost and implement the National Action on Gender-based Violence** and mobilize support from all sectors including government, legislature, judiciary, civil society, traditional authorities, faith-based organizations, media, private sector and community members.

3. **Strengthen linkages** between the medical (such as care and treatment), law enforcement (such as reporting and protection), and legal (such as a survivor's access to justice) responses to GBV to ensure survivor safety, effective prosecution of cases and uphold perpetrator rights to a fair trial.

4. Create procedures to allow for a robust and harmonized **chain of custody** of evidence across the medical, police and legal levels that ensures the plausibility of cases in court.

5. Share information on the national protection **referral network** among service providers, faith-based organizations, traditional leaders and community members in all regions and in multiple languages.

6. Set up a functional **multi-sectoral coordination mechanism** with stakeholders from various ministries and civil society. Ensure the organization and facilitation of **regular meetings** between service providers for improved collaboration.

7. Develop a comprehensive and **harmonized data system** to effectively document, respond and manage reported cases of GBV. Proper information and records management is essential for improving institutional response capacity and can be a valuable tool for internal accountability and performance monitoring.

8. Collect strategic **evidence on the linkages of GBV and HIV** in Namibia to inform policymaking and programming and to simultaneously address these two mutually reinforcing epidemics.

9. **Sensitize and train all service providers** including the police, WACPU, the judiciary, health professionals and civil society on how to effectively identify and respond to the various forms of gender-based violence (including emotional violence) as experienced by different groups to ensure compassionate, timely, efficient, and high-quality care to survivors of GBV.

10. Establish a free national **helpline** (preferably developed and implemented by a civil society partner) for survivors to receive immediate information and advice in an atmosphere of anonymity. Helplines provide low-threshold services and are an important gateway to other services such as safe houses or the police. The national helpline should be free of charge, operate 24/7, be accessible on a national level and in various languages, have professionally trained staff who specialize in GBV and receive government funding to ensure the provision of service is sustainable.

11. Increase number of **shelters** so that female survivors of GBV and their children can access immediate and safe accommodation. Services should be run by independent NGOs and be supported by government. The principle of independence is important to ensure that the interests of survivors and their children are central to the activities of the organization running the service. The organization should be only dedicated to the rights and needs of survivors and should not be influenced by any party, religious group, state authority or any other institution.

12. Pilot the concept of a **safe house for male victims** of GBV to assess their acceptability and utilization by men and boys who require safe accommodation.

13. Set up **transitional and longer-term shelters** for survivors, as well as low-cost housing for survivors and their children or other dependents.

14. Take into consideration the risk profiles and **needs of different groups of GBV** including those of particularly vulnerable populations such as LGBTIs, sex workers and people with disabilities in policy making and programming and develop specialized services to ensure that their needs are effectively met.

15. **Estimate all GBV related costs** (including the intangible psychological costs) to ensure that GBV is ranked high in terms of investment when it comes to resource allocation and priority setting within countries. Quantifying the costs of GBV also validates survivors' experiences and shows that their suffering has a wider societal impact.

Legal

1. Provide survivors with access to **free legal advice and/or aid** as otherwise their financial situation may hinder them from exercising and claiming their rights. Given that their legal situation may be complex, due to divorce, child custody, court proceedings victims often need legal advice and legal representation that is offered free of charge.

2. Train prosecutors on **effective prosecution strategies** and assign particular individuals or a team of prosecutors to handle GBV prosecutions to ensure access to justice for survivors of GBV.

Health sector

1. Develop relevant **standards and protocols**, which can guide care providers, facilitate monitoring of services, and ensure delivery of high-quality care.

2. Provide **survivor-centred, age-appropriate and non-discriminatory** health services in line with standards and protocols.

3. Establish private/ **confidential spaces** for waiting and consultation in hospitals.

4. Provide survivors of GBV with immediate and longer-term psychological **counselling** to reduce trauma.

5. Offer psychological **counselling to perpetrators** of violence to end the pattern of violence, and help them assume personal responsibility for the violence that they inflicted.

6. Train and recruit **forensic nurses** to secure evidence from rape victims.

7. **Integrate GBV survivor support into reproductive health and HIV programmes** to utilize linkages by routinely screening for GBV and counsel or refer them to prevent a first experience of violence, or work with them to prevent recurrence, and by including HIV into GBV response efforts.

8. *Provide sexual violence-related medication such as Post-Exposure Prophylaxis (PEP)*, **emergency contraception and antibiotics at WACPU station**.

Law enforcement

1. Provide a **separate room at police stations** for survivors to report the crime and for evidence to be collected and recorded in an atmosphere of privacy.

2. Provide **24 hour services**, 7 days a week preferably through permanent staffing. If not, through improving the on-call system by increasing the number of officers working at night so that they can go to the site of abuse.

3. Set up a **free telephone line** for survivors of violence and others to report incidents of violence to police and follow up on cases.

4. Ensure that WACPU officers consistently wear **civilian clothing** and nametags to make survivors feel more comfortable talking to officers, and allow individuals to report individuals who do not provide appropriate services in a professional, yet empathetic manner.

Civil society

1. Establish mechanisms to **strengthen the national women's movement**. Research shows that one of the most important predictors that a state will successfully reduce gender-based violence and provide comprehensive and quality services is the existence of a vibrant national women's movement.[41]

41. S. Laurel Weldon & Mala Htun (2013) Feminist mobilisation and progressive policy change: Why governments take action to combat violence against women, *Gender & Development*, 21:2, 231-247

2. **Increase government funding** of civil society response services and/or outsource the provision of services to NGOs, i.e. running of shelters, GBV hotlines etc.

3. **Enhance collaboration** between NGOs working in the field of GBV to improve civil society driven response to GBV.

4. Form **partnerships** between HIV serving organizations and civil society actors focusing on GBV

5. Programmes focusing on **women's empowerment** should be implemented so that victims can win back their autonomy, self-esteem, and sense of agency.

6. Increase the **involvement of men and boys** in preventing and responding to gender-based violence using a human rights approach.

Community

1. **Link GBV and HIV** in awareness raising programmes and mass media campaigns to highlight the mutually reinforcing relationship between the two epidemics.

2. Develop and implement programmes that seek to **transform harmful gender norms** and relations from a human rights perspective.

3. Form **survivor support groups**/networks that provide basic emotional support and information about availability of services. Explore the possibility of linking GBV in existing HIV related support groups.

4. Establish **support groups for perpetrators** to learn different patterns of behaviour and cope with responsibility of harm perpetrated.

5. Engage in **peer education and community mobilization** to break the silence around GBV and promote a zero tolerance of GBV. Develop community-based GBV prevention strategies to strengthen grassroots initiatives against any forms of GBV.

6. Educate community members on where and how to access services and inform them about the **referral pathways** among service providers.

7. Develop and **disseminate information** in relevant languages on laws and rights and on service availability through information boards, information sessions, radio shows etc.

Additional Recommendations Generated during the Stakeholder Consultation

1. Include traditional courts and traditional leaders into any legal recommendations, as they are key stakeholders.

2. Strengthen linkages between medical law enforcement, legal community private sector responses to GBV.

3. Develop programmes specifically focused on boys.

4. SOPs should be written into legislation to formalize their use.

5. Develop MoUs/service agreements for all stakeholders to clarify accountability.

6. Allocate budgets for WACPUs and shelters.

7. The private sector should be encouraged to take a more visible role in the GBV response

8. Faith Based Organisation and Faith Leaders should incorporate GBV issues in their Sunday sermon and Bible studies.

ANNEX 2: LIST OF CONTRIBUTING ORGANIZATIONS

The following organisations contributed to the process of developing this assessment and mapping.

Association for the Alternatives to Violence Project
Friendly Haven
Legal Assistance Centre
Lifeline/Childline
Ministry of Health and Social Services
Ministry of Gender Equality and Child Welfare
Ministry of Safety and Security
NamPol
NAPPA
University of Namibia Social Work Programme
Namibia Women's Health Network
Society for Family Health
Sister Namibia
The Swapo Party Women's Council
UN Gender Theme Group
USAID
Women and Child Protection Unit
Women's Solidarity Namibia

ANNEX 3 – MAPPING OF ORGANIZATIONS PROVIDING GBV FOCUSED SERVICES

As explained in the methodology of this document, as part of the overall exercise, a mapping was carried out to identify organizations that are providing GBV-focused services in Windhoek. It should be noted that the organizations included in this list are considered to have a considerable focus on GBV. There are a number of other organizations that provide peripheral or referral services, and many of these were identified during the stakeholder consultation. It is clear that such referral services are essential, yet in order to be concise and focused it was decided to limit the mapping to those organizations who are most focused on GBV.

Additionally, while it cannot be guaranteed that all relevant organizations were included, all efforts were taken to be as comprehensive as possible. This mapping is a living document; it should be updated on a regular basis in order to provide the most complete and accurate information and help to those who are in need of services.

AIDS CARE TRUST - Civil Society Organisation

CONTACT DETAILS
AIDS Care Trust
1005 Ondoto Street, Okuriangava
P.O.Box 8170, Bachbracht
Tel: 061-259590
Fax: 061-218673

DESCRIPTION
Established in 1992, the organisation has 2 branches in Namibia in which both staff and volunteers receiving GBV sensitization training.

MAIN SERVICES
- Home-based care services
- Psychological counselling service for survivors of GBV and support group for GBV survivors
- Material support, income-generation, job creation
- Health, medical support, first aid
- Information and advice centre
- Awareness-raising
- Training
- Referral

TARGET GROUP
Survivors of GBV (female, male, children) and policy making bodies

GEOGRAPHICAL COVERAGE
Khomas, Oshikoto, Omusati and Oshana

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes. During their interventions within the communities, discussions and talks are emphasising the linkages between GBV and HIV.

ASSOCIATION FOR THE ALTERNATIVES TO VIOLENCE PROJECT (AVP) NAMIBIA - NGO

CONTACT DETAILS
Association for the Alternatives to Violence Project
PO Box 26526, Windhoek
Secretariat: avp.namibia@gmail.com
Training coordination: avpntraining@gmail.com
Fax: 088-636770
Web: avpinternational.org
Contact person
Chairperson: Helen Vale
081-2839097

DESCRIPTION
AVP was initially introduced to Namibia in 2006 and administered by PEACE-Centre. AVP Namibia was registered in 2010/11 as an independent organisation and seeks to show alternative ways of dealing with potentially violent situation to peacefully transform challenging situations. Therefore all volunteers, working also as AVP facilitators are sensitized on various forms of violence, including GBV.

MAIN SERVICES
- Conferences/workshops
- Awareness-raising
- Training

Because the association is newly founded in Namibia, the following services are expected to be provided in future but are not implemented yet:
- Psychological counselling service for survivors of GBV
- Counselling for child survivors
- Support group for GBV survivors

TARGET GROUP
AVP is working with various types of offenders in prison, but is also planning to cover a broader variety of other target groups in the future (youth, male-support groups, refugees, LGTBI groups)

GEOGRAPHICAL COVERAGE
Locally located - Windhoek for the establishment, but regional workshops are possible. Some of the AVP Facilitators are based in other regions such as Rundu and Keetmanshoop.

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes. During workshops participants are asked to choose their own topic that will be deepened during the course of the workshop. This includes discussions of how the chosen topic is contributing to the increase of violence and what alternatives exist. Gender-based Violence is very often part of AVP-Workshop discussions, and HIV/AIDS is also touched on.

BLUE CROSS NAMIBIA - Faith-Based Organisation

CONTACT DETAILS
Blue Cross Namibia
1 Ara Street, Dorado Valley
Windhoek
Tel: 061-400473

DESCRIPTION
Established in 2008, Blue Cross Namibia is a non-profit organization registered with the Ministry of Trade. Blue Cross Namibia organizes prevention and awareness programmes at schools and in the community to encourage young people and the general public to live their lives free from drugs and alcohol, to provide an alternative to drugs and alcohol abuse. It is the mission of Blue Cross Namibia to reduce the consumption of alcohol, drugs and other related addictions by active involvement of communities through programmes on prevention, treatment, care and support. Blue Cross Namibia is the Namibian branch of the International Blue Cross which is a worldwide health development organisation dedicated to caring for people harmed by alcohol and/or illicit drugs.

MAIN SERVICES
- Information services
- Advocacy and lobbying
- Awareness-raising

TARGET GROUP
Policy making bodies and perpetrators of GBV

GEOGRAPHICAL COVERAGE
International

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Blue Cross works with Drug and Alcohol Addicts in relation to GBV. Prevention programmes explain how substance abuse causes people to indulge in many risky behaviours resulting in HIV and AIDS and how GBV will affect the family.

CATHOLIC AIDS ACTION (CAA) - Faith-Based Organisation

CONTACT DETAILS
Catholic AIDS Action
12 Adler Street
Windhoek West, Windhoek
P O Box 159, Windhoek
Tel: 061-276350
Fax: 061-276364
Mail: info@caa.org.na
Web: www.caa.org.na
Contact person
Godwin Chisenga: Executive Director
Tel: 061-276356
Cell: 081-1299532
Mail: godwin@caa.org.na

DESCRIPTION
Established in 1998, the organisation has 9 branches in 10 regions and focuses on providing protection and care for people living with HIV and Orphans and Vulnerable Children (OVC).

MAIN SERVICES
- Care and support for people living with HIV and OVC
- Home-based care
- Information services
- Advocacy and lobbying
- Awareness-raising

TARGET GROUP
People living with HIV and OVC

GEOGRAPHICAL COVERAGE
Caprivi, Erongo, Hardap, Karas, Kavango, Kunene, Ohangwena, Omaheke, Omusati and Oshana

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
No. However, through interactions between volunteers and HIV clients (using the family cantered approach) CAA refers victims of GBV to the Women and Child Protection Units churches, social workers and local leaders where applicable.

C-CHANGE - NGO

CONTACT DETAILS
Contact person
Dr Stephanie v.d. Wart
10 von Eckenbrecher Street
Klein-Windhoek, Windhoek
Cell: 0811246252

DESCRIPTION
C-Change provides technical assistance provided on behavioural change communication. They train the Health Extension workers, and as part of that training (currently in the northern regions), Health Extension workers are taught to identify GBV and refer to social workers. C-Change also helps link the Health Extension workers with trainings on gender and culture so they can develop self-awareness

MAIN SERVICES
- Training
- Technical assistance

TARGET GROUP
Health extension workers

CHANGE ORGANISATION - NGO

CONTACT DETAILS
Change Organisation (*Formerly known as Criminal Return to Society - CRIS)*
20 Wecke Street
Tal Terrace Bldg. Unit 6 & 10
Windhoek West, Windhoek
Tel: 061-229885

DESCRIPTION
Established in 2001, this rehabilitation program for ex-prisoners seeks to empower and support ex-prisoners to facilitate their return to society. The staff members do not receive GBV sensitization training.

MAIN SERVICES
- Income-generation and job creation
- Information services
- Training
- Referral

TARGET GROUP
Male and female ex-offenders

GEOGRAPHICAL COVERAGE
National coverage but Windhoek-based

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes.

COUNCIL OF CHURCHES IN NAMIBIA - Faith-Based Organization

CONTACT DETAILS
Council of Churches in Namibia
8521 Abraham Mashego Street, Katutura
P.O. Box 41, Windhoek, Namibia
Tel: 061-374050
Mail: info@ccnnamibia.org
Web: www.ccnnamibia.org
Contact person
Reverand Dr. Tshapakaisha-Kapolo (Coordinator of the Unit Faith, Justice and Society)

DESCRIPTION
Established in 1978, this umbrella organization consisting of all major churches in Namibia provides further opportunities for the various church denominations to come together to share their experience and make joint statements on matters of common interest. The pastors receive some GBV sensitization training through the seminaries.

MAIN SERVICES
- Psychological counselling service for survivors of GBV
- Counselling for child survivors
- Consultancy and Advocacy
- Conferences and workshops
- Lobbying
- Awareness-raising campaign
- Training
- Information services

TARGET GROUP
Survivors of GBV and specific programmes for the sex workers

GEOGRAPHICAL COVERAGE
Local coverage in the 13 Regions due to the 18 churches members (which represents 90 per cent of the population)

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes. Through marital counselling, the issues of HIV testing and the linkages between HIV and GBV are raised.

DESERT SOUL - NGO

CONTACT DETAILS
Desert Soul Health and Development Communication
2128 Independence Avenue, Katutura (Red Cross Offices)
Tel: +264 61 387450
Fax: +264309763
E-mail: info@desertsoul.org
Web: http://www.desertsoul.org
Contact person
Celia Kaunatjike (Executive Director)
Cell: +264811294427
E-mail: Celia@deserthdc.com

DESCRIPTION
Desert Soul's mission is to encourage healthy choices by children and adults on critical issues such as HIV/AIDS through communication that promotes social and behavior change.

Desert Soul's role is to provide world-class health communication through multi-media, community mobilization and advocacy.

MAIN SERVICES
- Awareness raising
- Advocacy
- Lobbying

TARGET GROUP
Women and girls subject to GBV, community and traditional leaders, community members

GEOGRAPHICAL COVERAGE
Khomas (Khomasdal, Havana and Okahandja Park) and Zambezi (Kabbe, Katima Urban and Rural Constituencies) regions

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes

FRIENDLY HAVEN - Civil Society Organization

CONTACT DETAILS
Friendly Haven
Khomasdal, WINDHOEK
PO BOX 10081
Cell: 081-1243010
Mail: esda@iway.na
Contact person
Jacky Hoff (Director)

DESCRIPTION
Established in 1996, this shelter is a project of the Ecumenical Social Diaconate Action (ESDA). Friendly Haven provides safe housing to women and their children in Windhoek. All staff members receive GBV sensitization training.

MAIN SERVICES
- Refuge / Shelter
- Psychological counselling service for survivors of GBV
- Lobbying
- Awareness-raising campaign
- Training
- Information services

TARGET GROUP
Female and children survivors of GBV

GEOGRAPHICAL COVERAGE
Local coverage - Windhoek

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes. They take into account the HIV status of clients and ensure their well being through ensuring adherence to ARV treatment as well as providing nutritional meals. They also provide assistance to survivors to access ARV.

INTERIM NIGHT SHELTER - Governmental Organisation

CONTACT DETAILS
Interim Night Shelter
Safari Street, Grysblock, Windhoek
Tel: 061-212962
Contact person
Ms Mbaukua

DESCRIPTION
The shelter run by Ms Mbaukua welcomes the child victims of GBV, street kids or any OVC and provides counselling as well as daily help (school support, food,) but no specific GBV training is provided to the workers of the shelter.

MAIN SERVICES
- Refuge shelter for children
- Counselling for child survivors

TARGET GROUP
Child survivors of GBV

GEOGRAPHICAL COVERAGE
Locally situated in Katutura

LEGAL ASSISTANCE CENTRE (LAC) - NGO

CONTACT DETAILS
Legal Assistance Centre
PO Box 604
4 Marien Ngouabi Street
Windhoek, Namibia
Tel: 061-223356
Fax: 061-234953
Mail: info@lac.org.na
Web: www.lac.org.na

DESCRIPTION
Established in 1989, this law firm's main objective is to protect the human rights of all Namibians through a multi-functional approach. All the staff members are trained by GRAP.

MAIN SERVICES
- Legal information for GBV survivors
- Advocacy
- Lobbying
- Awareness campaign
- Training
- Research
- Information services

TARGET GROUP
Female survivors of GBV, male survivors of GBV, child survivors of domestic violence, policy making bodies and service providers

GEOGRAPHICAL COVERAGE
National

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes. Through information support

LIFELINE/CHILDLINE - Community-Based Organisation

CONTACT DETAILS
LifeLine/ChildLine
45 Bismarck Street
Windhoek
Tel: 061-226 889
Fax: 061-226 894
Email: info@lifeline.org.na
Web: namibie.chisites.org
Contact person
Simone Hakid (Gender and Child Protection Program Manager)

Brigit Rudd (Gender programmes Manager)
Email: Brigit.rudd@lifeline.org.na

DESCRIPTION
Established in 1980, this child protection organization has 5 branches in Namibia and aims at building emotional resilience and skills development for all Namibians in a changing social environment. All the counsellors receive sensitisation to GBV Training.

MAIN SERVICES
- Psychological counselling service for survivors of GBV
- Counselling for child survivors
- Consultancy and Advocacy
- Conferences and workshops
- Lobbying
- Training

TARGET GROUP
Female/Male, youth, children, adults, victims, perpetrators and all those affected.

GEOGRAPHICAL COVERAGE
Regional: Kavango (Rundu), Hardap (Rehoboth), Khomas, North Central (Ondangwa & Oshikango)

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes. Through counselling, IPC sessions, HIV support groups and gender, behavioural change trainings and workshops discussing cultural and social norms and the linkages between GBV&HIV.

MEN & WOMEN NETWORK - Community-Based Organization	
CONTACT DETAILS Men & Women Network Julius Nyerer Street Okahandja Park Collaboration with NamPol **Contact person** Mr. Ndara Cell: 081 43 49 487 or 081 30 38 178	**DESCRIPTION** The aim of this CBO is to make Okahandja Park free from violence, for it to be a safe place by patrolling and working in collaboration with the police. It also involves the neighbourhood and community leaders.
MAIN SERVICES - Legal support in the police station - Home-based care - Referral and reporting cases to the police - Emergency intervention in the neighbourhood - Patrolling with volunteers - Counselling	
TARGET GROUP Women and children	
GEOGRAPHICAL COVERAGE Locally: Okahandja Park	
ADDRESSING THE LINKAGES BETWEEN GBV AND HIV No.	

MISA- MEDIA INSTITUTE OF SOUTHERN AFRICA (NAMIBIA) -Civil Society Organisation	
CONTACT DETAILS Email: director@misanamibia.org.na Tel: 061232975 **Contact Person** Natasha Tibinyane	**DESCRIPTION** MISA is a media institute, and as such does not do any service provision. Their work is related to GBV such that they try to use the media to raise awareness of the issue. For example, they are holding a media and information literacy retreat for youth with a focus on GBV. They recently health a youth retreat during which participants assisting in developing campaign messages for the upcoming 16 days campaign.
MAIN SERVICES - Media sensitizing - Prevention - Awareness raising - Addressing harmful norms	
TARGET GROUP	**GEOGRAPHICAL COVERAGE**
ADDRESSING THE LINKAGES BETWEEN GBV AND HIV	

MOVE NAMIBIA - Civil Society Organisation

CONTACT DETAILS
Move Namibia
Tel: 085-3286746
Mail: movenamibia@gmail.com
Web: movenamibia.webs.com
Contact Person
Nelao Hamunime
Mail: nelao.hamunime@za.ey.com

DESCRIPTION
Established in October 2012, this youth organization gathers young people to say no to GBV in Namibia. Based on social network mobilization (such as Facebook or Twitter), the organization has reached people all around Namibia. Move Namibia employs a social worker who is tasked to sensitize the members of the organization on GBV.

MAIN SERVICES
- Information services
- Awareness-raising
- Advocacy and lobbying
- Referral
- Conferences/workshops (in project)

TARGET GROUP
Survivors of GBV and policy making bodies.

GEOGRAPHICAL COVERAGE
National coverage

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
No.

NAMIBIA RED CROSS SOCIETY - Community-Based Organization

CONTACT DETAILS
Namibia Red Cross Society
2128 Independence Avenue (Shoprite)
Katutura
Web: www.redcross.org.na
Contact person
Kuniberth Shamathe
Tel: 061-413772
Mail: kuniberth.Shamathe@redcross.org.na

DESCRIPTION
Namibia Red Cross Society provides humanitarian aid with a focus on health and care. Established in 1954 the Head Office is based in Windhoek.

MAIN SERVICES
The main activities of the NRCS can be described as "gender-related services in the refugee camps". In case of emergency the NRCS provide interventions such as:
- Psychological counselling
- Support group
- Medical support
- Training: the GBV component is integrated to the health or emergency trainings delivered to the volunteers and regional coordinators who deal with the emergency situation. No specific focus on GBV.

TARGET GROUP
Survivors of GBV, identified as mostly woman and children even if not specifically targeted, who are confronted with violence in refugee camps

GEOGRAPHICAL COVERAGE
There are 8 regional offices in Khomas, Kunene, Caprivi, Kavango, Ohangwena, Omusati, Oshikoto and Khorixas regions, with GBV officers in 3 regions: Omusati, Kavango and Caprivi.

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes. HIV is a cross cutting issue for all activities. Their beneficiaries or volunteers are mostly people living with HIV receiving home-based care. They provide GBV trainings which discuss link of GBV and HIV. NRCS also had HIV/AIDS awareness programmes.

NAMRIGHTS - Civil Society Organisation

CONTACT DETAILS
NamRights
(Formerly known as National Society for Human Rights NSHR)
116 John Meinert St
Windhoek-West
P. O. Box 23592
Windhoek
Tel: 061-236183 or 061-253447
Fax: 061-234286
Mail: nshr@iafrica.com.na or nshr@nshr.org.na
Web: www.nshr.org.na
Contact person
Phil ya Nangoloh

DESCRIPTION
Founded in 1989 by concerned citizens, the organization envisages a world free of human rights violations. Its mission is to stop human rights violations in Namibia and the rest of the world. The organization seeks to secure all human rights and fundamental freedoms, especially those enshrined in the Namibian Constitution and to promote democracy as well as cultural, social and political tolerance for all.

MAIN SERVICES
- Human rights monitoring and evaluation (including cultural, women, children rights)
- Awareness-raising
- Advocacy through shadow reports

TARGET GROUP
NamRights doesn't have a specific target group. In the case of GBV, the rights of women and children are violated because they are the most vulnerable people. That's why NamRight is mostly working with these groups.

GEOGRAPHICAL COVERAGE
Nationally: 1 head office in Windhoek and 4 offices in the regions (Caprivi, Ohangwena, Oshana, Oshikoto) which report to the Khomas office.

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes. During the trainings and the workshop, the linkages between GBV and HIV are addressed.

NAMIBIAN SEX WORKERS ALLIANCE (NAMSWA) - CSO

CONTACT DETAILS
Namibian Sex Workers Alliance (NAMSWA)
131 Johan Albrecht Street
Windhoek North, Windhoek
Contact person
Jeremia Morkel
Cell: 0814316719

DESCRIPTION

MAIN SERVICES
- Empowerment
- Universal health care system & Justice system
- Partnership development
- Capacity building
- Advocacy
- Communication
- Resource mobilization

TARGET GROUP
Sex workers and LGTBIQ

GEOGRAPHICAL COVERAGE
In all 14 regions

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV

NAMIBIA PLANNED PARENTHOOD ASSOCIATION (NAPPA) - NGO

CONTACT DETAILS
Namibia Planned Parenthood Association
P.O Box 10936
Khomasdal
Windhoek
Tel: 061-230250 or 061-230251
Mail: info@nappa.com.na
Web: www.nappa.com.na

DESCRIPTION
NAPPA was established in 1996 to complement the Government's efforts in the provision of sexual and reproductive health information and services to the people of Namibia. The organisation has 6 Clinics in Namibia where psychological counselling service for survivors of GBV as well as information and advice are provided. However, no specific training on GBV seems to be available for the medical workers.

MAIN SERVICES
- Psychological counselling service for survivors of GBV
- Information services
- Support group for GBV survivors
- Health /medical support/first aid

TARGET GROUP
Female survivors of GBV

GEOGRAPHICAL COVERAGE
Regional coverage: Khomas, Erongo, Caprivi, Omusati, Ohangwena, Karas

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
All services of NAPPA are linked through the integration of SRH services with HIV, all clients who come for HIV are screened for GBV. If they are GBV victims they are counselled and referred to Women and Child Protection Unit for further counselling and other necessary interventions. All GBV survivors are referred to HIV counselling and testing.

NAMIBIAN WOMEN'S ASSOCIATION (NAWA) - Civil Society Organisation

CONTACT DETAILS
Namibian Women's Association (NAWA)
John Knox Street
Maroela, Katutura, Windhoek
P.O. Box 3370
Tel: 061-262461
Fax: 061-213379
Mail: nagirlch@iway.na

DESCRIPTION
Established in 1979, the women's rights NGO is involved in child protection. NAWA has several branches in Namibia but some of them are dormant this year. Therefore only one staff member was trained on GBV this year.

MAIN SERVICES
- Empowerment of children
- Advocacy and lobbying

TARGET GROUP
All marginalised children

GEOGRAPHICAL COVERAGE
National coverage

NAMIBIA WOMEN'S HEALTH NETWORK (NWHN) - Civil Society Organisation

CONTACT DETAILS
Namibia Women's Health Network
22 Johanna Albrecht Street
Windhoek West
Tel: 061-220117
Fax: 061-232293
Mail: nwhn@criaasadc.org
Web: nwhn.wordpress.com

DESCRIPTION
Established in 2008, this women's right organization provides information, education and skill trainings to improve the health of Namibian women living with HIV and to empower them to become leaders. All staff members, interns and volunteers who will be with the organization on a long term basis receive GBV sensitization training.

MAIN SERVICES
- Psychological counselling service for survivors of GBV
- Counselling for child survivors
- Information services
- Advocacy and lobbying
- Support group for GBV survivors
- Conferences and workshops
- Awareness-raising
- Training
- Research
- Referral

TARGET GROUP
Survivors of GBV (Female and Children) and policy making bodies

GEOGRAPHICAL COVERAGE
Local actions and national coverage with the presence of a focal people in each 13 regions who report back to the main office based in Windhoek.

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
NWHN is involved in carrying out workshops training and discussions where men and women discuss cultural and social norms and the linkages between GBV and HIV.

OUT-RIGHT NAMIBIA (ORN) - Civil-Society Organization

CONTACT DETAILS
Out-Right Namibia
131 Johann Albrecht Street
Windhoek North, Windhoek
Tel: 061-237329
Mail: outrightnamibia@gmail.com
Contact person
Natasha Tibinyane

DESCRIPTION
This LGBTI, MSM and WSW human rights based organization was formed in 2010 by self identified LGBTI, MSM and WSW activists and got officially registered as a Trust. ORN advocates as the voice of LGBTI people to be heard in Namibia to address homophobia in Namibia. All programmes staff and the field staff that work in the regions received training on GBV.

MAIN SERVICES
- Psychological counselling service for survivors of GBV
- Support group for GBV survivors
- Advocacy
- Conferences/workshops
- Referral
- Awareness-raising

TARGET GROUP
Female and male survivors of GBV

GEOGRAPHICAL COVERAGE
Regional coverage: Khomas, Otjozondjupa, Karas, Kunene, Hardap, Erongo, Oshana and Oshikoto.

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
ORN looks at how women and men in the communities construct their gender identities and roles, how they understand GBV, and what they believe about the links between gender relations and HIV risk. ORN carried out primary research and the key findings included the perception that although traditional gender roles were still very much in existence, shifts in gendered power relations are occurring. Developing effective HIV/AIDS interventions in these communities will require tackling the overlapping as well as divergent constructions of gender, gender violence and HIV.

OMBETJA YEHINGA ORGANISATION (OYO) - Civil Society Organisation

CONTACT DETAILS
Ombetja Yehinga Organisation (OYO) Trust
PO Box 97217
Maerua Park
Windhoek
Tel: 061-254915
Mail: info@ombetja.org
Web: ombetja.org

DESCRIPTION
Established in 2003, OYO is an information and advice centre in terms of GBV. All OYO staff employed before 2012 received training on GBV but the ones who joined in 2012 or 2013 still need to go through the training.

MAIN SERVICES
- Information services
- Referral
- Advocacy and lobbying

TARGET GROUP
Young people in and out of school as well as policy making bodies

GEOGRAPHICAL COVERAGE
National coverage

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Through various activities the links between GBV and HIV are addressed. For example their DVD 'Now that I can talk about it' speaks directly about rape by a family member and the risk of HIV infection. Some dance pieces or theatre pieces with youth groups do the same. Some of the OYO magazine articles deal with the issue. When facilitating discussions around the DVD, magazine or shows, OYO tries and encourages their target audience to reflect on the link.

PEACE CENTRE - Civil Society Organisation

CONTACT DETAILS
PEACE Centre
26 Rhino Street
P.O. Box 50617
Bachbrecht, Windhoek
Tel: 061 2012345 / 061 371550
Fax: 061 371555.
Email: info@peace.org.na
Web: www.peace.org.na
Contact person
Dr. Hetty Rose-Junius (Director)
Mail: hetty@peace.org.na

DESCRIPTION
PEACE is an acronym for People's Education, Assistance and Counselling for Empowerment. The PEACE Centre provides psychosocial counselling and tries to identify, through comprehensive needs assessments in affected communities, the ways in which it can develop already existing local knowledge and skills in the field of psychological interventions. This includes the provision of ongoing supervision after basic training has been completed. In this manner local communities can be empowered. All the counsellors are offering pro-bono services to the PEACE Centre to sensitize the staff members to GBV.

MAIN SERVICES
- Psychological counselling for survivors of GBV
- Counselling for child survivors
- Consultancy and Advocacy
- Conferences and workshops
- Awareness campaign
- Training
- Information services

TARGET GROUP
Female survivors of GBV, child survivors of domestic violence and policy making bodies

GEOGRAPHICAL COVERAGE
Local, regional, national and international coverage. Windhoek based but PEACE Centre staff travels to carry out trainings, community awareness raising campaigns and group counselling sessions all around Namibia except in Omusati and Kunene regions due practical and financial issues.

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
The linkages between GBV and HIV are addressed in awareness campaign and as part of the counselling.

PHILIPPI TRUST NAMIBIA - NGO

CONTACT DETAILS
Philippi Trust Namibia
Erf 7693 Ara Street
Dorado Park, Windhoek
Tel: 061- 259291
Web: www.philippinamibia.com

DESCRIPTION
The organization was established in Namibia in 1996 but registered as a Welfare Organisation in 1999. The Philippi Trust Namibia has only one branch in Namibia although it is settled in different regions. It provides counselling and child protection services to GBV survivors. All staff members working with clients receive GBV sensitization training.

MAIN SERVICES
- Psychological counselling for survivors of GBV
- Counselling for child survivors
- Training

TARGET GROUP
Survivors of GBV

GEOGRAPHICAL COVERAGE
Regional: Khomas, Otjozondjupa and Erongo

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Through counselling and referral to VCT facilities and ARV clinics

PROJECT HOPE - NGO

CONTACT DETAILS
Project Hope
19 Bach Street
Windhoek West
PO Box 23079 Khomasdal
Tel: 061377850
Fax: 061377853
Contact person
Denise Moongo, Chief of Party
Cell: 081-4700540

DESCRIPTION
Founded in 1958, Project HOPE (Health Opportunities for People Everywhere) is dedicated to providing lasting solutions to health problems with the mission of helping people to help themselves. Started health care services and providing health education in Namibia in 2002.

MAIN SERVICES
- Parental and education training for households and communities caring for orphans and vulnerable children, as well as programmes providing economic strengthening opportunities
- HIV/AIDS Prevention
- Micro-credit loans for young women to prevent them from the engagement in sex work
- Community based GBV Care, training curriculum on GBV and his impacts for OVC Caregivers.
- In the near future there will be a new program available which aims to link community members with a need of help to appropriate services (GBV victims).

TARGET GROUP
Key populations

GEOGRAPHICAL COVERAGE
Zambesi, Kavango East and West, Omusati, Oshana, Oshakati.

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV

RIGHTS NOT RESCUE - Civil Society Organisation

CONTACT DETAILS
131 Johan Albrecht Street
Windhoek North, Windhoek
Contact person
Mama Africa
Tel: 081 2068240
Email: naoxamub@yahoo.com

DESCRIPTION
Programmes targeting sex workers, with a specific focus on MSM, transgendered individuals, and lesbians

MAIN SERVICES
- Outreach to sex workers
- Counselling and assessment to sex worker colleagues
- Documenting any reports of GBV
- Assesses documents through the SMS line through LAC
- Referrals to health service providers
- Lobby and advocacy
- Counselling
- Home based care
- SMS line on abuse

TARGET GROUP
Sex workers and LGTBIQ

GEOGRAPHICAL COVERAGE
Windhoek

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV

SCRIPTURE UNION NAMIBIA - Faith-Based Organisation

CONTACT DETAILS
Scripture Union Namibia
P.O Box 20754
Ara Street, Dorado Park
Windhoek
Tel: 061-240 541
Fax: 061-271 579
Mail: scriptureunion@iway.na
Web: www.sunamibia.org or http://su-international.org/

DESCRIPTION
Established in 1983, Scripture Union seeks to bring 'God's Good News' to children, young people and families and help people of all ages to meet God through the Bible and prayer. Scripture Union places an emphasis on helping community members grow in Christian maturity.

MAIN SERVICES
- Trainings
- Life-skills/camping ministry programmes
- Bible Guides/Values Education

TARGET GROUP
Children and young people

GEOGRAPHICAL COVERAGE
National coverage (present in 130 countries all over the world)

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Yes. Behaviour change discussion during camps and trainings during which linkages between GBV and HIV are addressed.

SISTER NAMIBIA - Civil Society Organisation

CONTACT DETAILS
Sister Namibia
PO Box 86753
163 Nelson Mandela Avenue
Eros, Windhoek
Tel. 061-230618/230757
Fax: 061-236371
Mail: director@sisternamibia.org or media@sisternamibia.org
Web: www.sisternamibia.org

DESCRIPTION
Established in 1989, this feminist, non-party political women's rights organisation works towards a society liberated from patriarchal domination in which all people have equal rights, are empowered to enjoy equal opportunities, and live in peace, prosperity and dignity. Its mission is to empower women and girls in the struggle for gender equity and equality through media work, research, capacity building, networking and collective action. To reach its goal, Sister Namibia publishes a quarterly magazine, runs a resource centre, provides training on women's human rights with a focus on political empowerment and sexual rights, and develops and implements campaigns on these issues. Sister Namibia provides GBV sensitization for all staff.

MAIN SERVICES
- Advocacy and lobbying
- Awareness-raising
- Conferences/workshops
- Information services

TARGET GROUP
The public at large, concentrating on women and girls

GEOGRAPHICAL COVERAGE
National coverage

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
The Sister Namibia SRH program delivers information about women's rights and Sexual and Reproductive Health Rights to women, which also includes information on the linkages between GBV and HIV.

TANIDARE EMPOWERMENT CENTRE - Faith-based Organisation

CONTACT DETAILS
Tenidare Empowerment Centre
2 Dagon Street
Katutura, Windhoek
Tel: 061-301820
Mail: tec@iway.na

DESCRIPTION
Established in 2002, this women's rights NGO is working closely with the Tanidare Parish to support and empower the vulnerable members of the parish. Workshops, seminars and training have been held on the Married Persons Equality Act, the Combating of Domestic Violence and Rape Acts, the Children's Status Bill, and HIV/Aids treatment and care. The staff members do not receive specific trainings on GBV.

MAIN SERVICES
- Information services
- Advocacy and lobbying
- Conferences/workshops
- Income-generation and job creation

TARGET GROUP
Survivors of GBV and young people

GEOGRAPHICAL COVERAGE
Local coverage

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
The Tanidare Empowerment Centre addresses the linkages between GBV and HIV through the facilitation of workshops.

THE URBAN TRUST OF NAMIBIA (UTN) - NGO

CONTACT DETAILS
The Urban Trust of Namibia (UTN)
3 Schönlein Street
Windhoek West
Private Bag 13291
Tel: 061-248708/10
Fax: 088-649126
Mail: urban@mweb.com.na
Contact person
Santos Joas (Executive Director)
Mail: utnjoas@mweb.com.na

DESCRIPTION
Established in 1994, UTN focuses on enabling communities, business associations, groups and institutions to promote effective, efficient, democratic and developmental forms of urban governance. UTN is a non-profit organisation registered as a charitable trust. UTN's programmes include advocacy on urban governance, policy development, and promotion of partnership, assistance in increasing accountability, research on policy issues and advisory services to groups and institutions in urban areas. UTN does not directly work with GBV. However, their safety program focuses on strategy and policy promotion on prevention of violence and crime broadly. The staff members do not receive specific trainings on GBV.

MAIN SERVICES
- Legal counselling for survivors of GBV
- Conferences/workshops
- Awareness campaigns
- Training
- Research

TARGET GROUP
Policy making bodies

GEOGRAPHICAL COVERAGE
National coverage. Head office in Windhoek; regional office in the Northern Cape Region; satellite office in Tsumeb and there is soon one to come in Rehoboth.

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
No.

VICTIMS 2 SURVIVORS - NGO

CONTACT DETAILS
Victims 2 Survivors
165 Independence Avenue
City Center, Windhoek
Contact person
Hem Matsi (President)
Mail: ladyhem@gmail.com

DESCRIPTION
Established in 2010, this NGO seeks to increase awareness on GBV. The staff members do not receive specific trainings on GBV.

MAIN SERVICES
- Legal counselling for survivors of GBV
- Awareness campaigns
- Lobbying
- Advocacy
- Training
- Information services

TARGET GROUP
Female survivors of GBV, young people and policy-making bodies

GEOGRAPHICAL COVERAGE
Windhoek-based.

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Through awareness campaigns.

WOMEN ACTION FOR DEVELOPMENT (WAD) - NGO

CONTACT DETAILS
3rd Ruhr Street
Northern Industrial Area
PO Box 370
Windhoek
Tel: 061-227630
Fax: 061-400156
Web: www.wad.org.na
Contact person
Bennet Bhebhe
Mail: bennet@wad.org.na

DESCRIPTION
Women's Action for Development (WAD) is a non-profit making, non-partisan NGO and has been operational in Namibia in 1994. It is a self-help organisation which follows a two-pronged program, namely the socio-economic and socio-political empowerment of rural women and men.

MAIN SERVICES
- Advocacy and lobbying
- Conferences/workshops
- Training
- Research such as: interviews with perpetrators, cultural studies, women and violence
- Referral

TARGET GROUP
Survivors of GBV (female, male, children)

GEOGRAPHICAL COVERAGE
Head Office in Windhoek and trainings centre in 3 regions: Omusati, Hardap and Karas.

WHITE RIBBON CAMPAIGN NAMIBIA - NGO

CONTACT DETAILS
White Ribbon Campaign Namibia Foundation
Etegameno Centre
Okuryangava, Katutura, Windhoek
P.O.Box .7005, Khomasdal
Cell: 081-2921195
Mail: wrcnamibia@gmail.com or simakumba@yahoo.com

DESCRIPTION
Formed in 2003, the organisation seeks to mobilize men to prevent GBV. Only the director received training on GBV.

MAIN SERVICES
- Conferences/workshops
- Awareness-raising
- Training
- Research
- Information services
- Advocacy and lobbying
- Sensitization to men and Boys
- Involvement of Men and Boys in violence Prevention and Maternal Health & Reproductive Health and care

TARGET GROUP
Men and boys and perpetrators of GBV

GEOGRAPHICAL COVERAGE
National coverage

ADDRESSING THE LINKAGES BETWEEN GBV AND HIV
Through education, discussions and actions.

YOUTH OUTREACH ON RIGHT AND DEVELOPMENT (YORD) - Community-Based Organization	
CONTACT DETAILS Kwella Court Eros, Windhoek Mail: Yordnamibia@gmail.com **Contact person** Justina Shilongo Tel: 0812117907	**DESCRIPTION** YORD is a NGO that is working with young survivors of GBV. The services provided include education, awareness raising, and referrals for health and social services. They are currently connected to the PLHIV support groups, and many referrals come from members. Once young people are identified who may be experiencing GBV, they are counselled individually.
MAIN SERVICES - Dramas on the links between GBV and HIV at the hostel grounds for pregnant women and at the regional hospital, thus attempting to educate on GBV awareness and healthy relationships. - Training/capacity building on HIV and GBV as well as SRHR in Windhoek.	
TARGET GROUP Youth, both male and female from the age of 16-35	**GEOGRAPHICAL COVERAGE** The organization is relatively new, and serves Khomas and Ohangwena regions
ADDRESSING THE LINKAGES BETWEEN GBV AND HIV In Ohangwena, the project links HIV and GBV and tries to educate young people about healthy relationships, contraceptive use, and condom negotiation. In this region, no one is really serving youth survivors, so contacts with school principals in villages gives access to an underserved populations.	